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THE ATTEMPTED DISMANTLING OF THE MEDICARE HOME CARE BENEFIT

A REPORT

BY THE

CHAIRMAN

OF THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

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FOREWORD

I am pleased to introduce this report, "The Attempted Dismantling of the Medicare Home Care Benefit," released to the Subcommittee on Health and Long-Term Care at its March 19, 1986 hearing, "Catastrophic Health Insurance: The Home Care Benefit," by the National Association for Home Care.

Since the Reagan Administration came to power in 1981, the Subcommittee has conducted a series of nationwide hearings addressing the crisis in health care currently facing our country. These sessions addressed the problems of rising costs and reduced benefits under the Medicare program. They also examined the solvency of Medicare. Perhaps the most jarring revelation in these nearly one dozen hearings was the lack of coverage under private and public health insurance for catastrophic illnesses such as Alzheimer's disease and certain types of cancer.

President Reagan, in his State of the Union message earlier this year, called catastrophic health insurance a top priority. He charged new Secretary of Health and Human Services, the Honorable Otis R. Bowen, M.D., to develop a plan to meet the catastrophic health care needs of Americans of all ages.

The Subcommittee was encouraged to hear of this initiative on the part of the Chief Executive and earlier this year we initiated a series of hearings on catastrophic health insurance. Dr. Bowen himself appeared at the first of these hearings on February 19, 1986, to describe some of his ideas for reform. Public witnesses who had firsthand experience with catastrophic illness shared their stories and their ideas for reform. Other policy experts also shed light on this challenging and yet critically important mandate -- to restructure the American health care system so as to include provision of reasonably priced, high quality health care for all types of illness, not just acute illness.

No long-term care system could be considered complete without the home care component. Home care is gaining greater support all the time as a humanitarian alternative to institutionalization which in many cases is also less costly. It is one of the building blocks of the continuum of care we are hoping to establish.

The Subcommittee on Health and Long-Term Care recently examined the status of home care in this country at its March 19 hearing, "Catastrophic Health Insurance: The Home Care Benefit." Public witnesses and policy experts extolled the virtues of home care and yet pointed to the paradoxical fact that the current Administration is scaling back support for this particular benefit, both through subtle and unsubtle means.

The report that follows is an exhaustive examination of the home care benefit since its inception as well as a summary of public attitudes toward this type of care.

I want to congratulate all persons who worked on the report, particularly Mr. Val Halamandaris and Mr. Bill Halamandaris. As we on the Subcommittee continue our work to refashion the American health care system, I know that we will look to this report again and again for guidance.

I commend the National Association for Home Care for its tireless and compassionate efforts to ensure a bright future for the health care system of the United States, of which this report is but one example.

I would also like to thank Subcommittee Staff Director Kathleen Gardner Cravedi for her usual excellent work in connection with our hearing on the home care benefit. Research Director Peter Reinecke and Assistant Staff Director Melanie Modlin also provided invaluable assistance in the organization of that hearing, as did Congressional Fellow Patricia Butch.

Claude Pepper
Chairman

THE ATTEMPTED DISMANTLING OF THE MEDICARE HOME CARE BENEFIT

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I. INTRODUCTION

I. INTRODUCTION

Home health care in the United States traces its origins back to 1885. Some 100 years ago the nation was confronted with serious health care problems. Smallpox, cholera and influenza epidemics were sweeping the nation. At the same time, a significant public health problem was presented by the tremendous influx of immigrants to American shores.

Those who migrated to the U.S. at the turn of the century generally did not speak English and did not understand much about Western medicine. They did not understand hygiene, sanitation and infection control. When sick, they took care of themselves as best they could with the folk medicines they had learned in their native lands.

It was these conditions which spawned the Instructive Visiting Nurse Societies throughout America. There was a severe shortage of physicians, so nurses and volunteers were pressed into service to deal with the growing national emergency.

Virtually every city in America soon boasted a Visiting Nurse Association (VNA). It became an item of community pride to be associated with a VNA. Americans of all ages and all walks of life began to volunteer some of their time in outreach services to the poorest of the poor.

Home health agencies thus were born in crisis, their primary purpose being to bring the rudiments of modern health care to those who could not integrate with the mainstream of American medicine. Nurses and volunteers sought out needy people in their respective residences and cared for them there. They went, as missionaries, into the slums of America's major cities seeking out the desperate and forgotten.

These worthy social endeavors were supported entirely by philanthropy. VNAs operated in this way for 80 years. But it wasn't until the enactment of Medicare in 1965 that most Americans learned about home health care.

In the preamble of the Medicare Act, Congress declared that access to quality health care services was the right of all Americans. Congress further specified that ability to pay should not be an impediment to the availability of such services. It naturally followed that home health was added as a benefit.

The addition of the home health benefit was supported by many members. Chief among them was Senator Frank E. Moss who then chaired the Subcommittee on Health and Long-Term Care of the Special Committee on Aging. Moss had presided over a series of highly publicized hearings on abuses perpetrated in nursing homes and other institutions. In 1964, Senator Moss introduced legislation intending to make home health care generally available to America's seniors as an alternative to nursing home placement.

As a result of the continuing efforts of Senator Moss and the Aging Committee, nursing homes and home health care became a major issue at the 1971 White House Conference on Aging. The Conference resolved that the nation should formulate a national policy on long-term care based upon home health care.

In 1972, Senator Moss helped Senator Gaylord Nelson push through an amendment to the Medicare Act which removed the coinsurance requirement in the home care benefit. In that same year, the Aging Committee issued a major report on the importance of broadening the scope of that benefit.

In 1974, the Committee began releasing the first of a 12 volume set of reports entitled "Nursing Home Care in the United States: Failure in Public Policy." The reports were issued on a monthly basis throughout 1975. A major conclusion of the report was that the Department of Health and Human Services (HEW as it was called then) had failed to make home health services available to the needy. The report notes that at that time, 3 million older Americans were housebound, bedfast or going without the in-home services that they needed. Said the report:

> "Thousands of seniors are going without the care they need. Perhaps most unfortunate, institutionalization could have been prevented or postponed for thousands of current nursing home residents if viable home health and supportive service existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients -- as well as substantially less expensive -- the Department of HEW has given only token support for such programs."

The report was highly critical of the Department because less than 1 percent of either Medicare or Medicaid programs went to pay for home health care. In 1976, Senator Moss and Congressman Claude Pepper introduced legislation to expand the limited Medicare home health benefit saying that home care should be the norm and nursing home care available only when home care is impossible or impractical.

The Senate Aging Committee has continued to press for liberalization of the home care benefit. Senator John Heinz, Committee Chairman, recently introduced legislation to deal with what he calls "no care zones." He sees "long-term care" as a looming problem which for too long has been swept under the rug. Senator Heinz and his committee released a report in September 1985 showing that one effect of the DRG reimbursement system for Medicare participating hospitals has been to move greater numbers of sicker patients into home health care sooner. The Senator notes at the same time that rather than expanding Medicare's home care benefit, the Department of Health and Human Services has been looking to cut back on the level of reimbursement. Says the Senator:

> "Limiting the use of the home health benefit could well be penny-wise and pound-foolish if failure to provide home care results in increased hospital and nursing home costs. It can make the difference for millions of our nation's most vulnerable citizens to remain in the best possible environment for their health and well-being."

The ranking Democrat on the Committee, Senator John Glenn, has been equally supportive. "We are eager to establish an efficient and cost effective home and community based health care system," he said recently.

But support of home care has not been limited to the U.S. Senate. In December, 1984, the House Committee on Aging under the Chairmanship of Congressman Claude Pepper, issued a report entitled "Building a Long-Term Care Policy: Home Care Data and Implications." Chairman Pepper said in his introduction, "There are few issues of greater importance to the Nation's elderly than home health care."

This was the fifth major report issued by the House Committee in its 10 year history which recommended that a national policy with respect to home care be established.

On February 1, 1978, the House Aging Committee passed a resolution calling for the "expansion of home health benefits under Medicare." At that time, Chairman Pepper released a Report of the U.S. General Accounting Office at that time which he said concluded that "in five out of six cases, home care was less expensive than institutional care."

In a 1980 report, "Medicare After 15 Years," the Committee again concluded there was a need to expand the scope of Medicare's home care benefit.

The Congress has responded to some degree to these recommendations. For example, in 1980, Congress removed the requirement that a beneficiary must first be hospitalized for 3 days consecutively in order to receive home health care benefits. Congress removed a limit of 100 visits per year and it removed a legal impediment which barred for-profit agencies from participating in the Medicare program.

In 1981, Congress created Medicaid's Section 2176 waiver program. This allows the states to experiment with home health care as a means of reducing their overall nursing home costs.

A year later, Congress created the so-called "Katie Beckett" waiver in which only the income of a minor child would be counted toward determining the eligibility of that child for pediatric home care. Eligibility is limited and is currently determined by a special Board within HHS on a case-by-case basis.

In 1982, Congress created the Medicare hospice benefit. Hospice is, of course, essentially home care for individuals who are terminally ill.

In 1983, Congress created the DRG prospective payment system for reimbursement of Medicare participating hospitals. The primary purpose of this system was to move patients out of hospitals into less expensive community-based home care services.

In 1984 and 1985, Congress rejected the Administration's proposal to require Medicare beneficiaries to pay coinsurance as a precondition of receiving home health services. The measure has been offered again in 1986.

In 1985, the Senate Finance Committee and House Ways and Means Committee cleared amendments extending the Medicare hospice benefit. The Senate Finance Committee agreed, in addition, to amendments making respiratory therapy available at home under both Medicare and Medicaid, preserving waiver of liability, and postponing the effect of HCFA's restrictive new cost limits. While the Congress has yet to act on final passage, it is clear that the 99th Congress, like most of its predecessors going back 20 years, will express its support for home care in the form of new legislation.

The support of home care in the Congress is grounded in the growing public recognition of home care as well as the growing need for it. For example, a 1983 poll by the Gallup organization for the American Association of Retired Persons (AARP) established that 80 percent of AARP members would prefer long-term home health

care to a long-term nursing home stay. AARP learned that the need for assistance with long-term care ranked number 1 among problems confronting older Americans. This finding was verified by a 1985 poll for the National Association for Home Care.

A 1982 report by the U.S. General Accounting Office indicated that there was high consumer satisfaction among those who received home care. This too was verified by the 1985 study for NAHC. GAO found that home care may actually serve to increase the quality of life for older Americans. Previous GAO reports have estimated that 25-40 percent of the residents in nursing homes would not need to be institutionalized if other alternatives were available. In its most recent report, GAO cautioned against the simplistic notion that all patients in nursing homes can be responsibly cared for at home and that this will be a less expensive way of caring for all of the nation's infirm aged. Careful targeting, said GAO, was essential if the goal to be achieved in home care was cost savings.

In this respect, Blue Cross/Blue Shield Association of America announced in July, 1985 that 90 percent of the nation's Blue Cross/Blue Shield plans now offer home health coverage "as an answer to high health care costs." The Maryland Blue Cross/Blue Shield organization reported savings of $1.2 million in 1982 because of its coordinated home care program. Similarly, Aetna Life and Casualty reported $60,000 per case savings from its Individual Care Management Program by using home care for victims of catastrophic accidents or illnesses."

It should also be pointed out in this introduction that support for home health care is bipartisan. It enjoys support among liberals, moderates and conservatives. For example, one of the strongest supporters of home care is Senator Orrin Hatch of Utah, who said:

> "It is not just the responsibility of Congress or the Federal Bureaucracy to formulate services to assist our sick elderly to remain at home. It is everyone's responsibility -- the private sector, medicine, citizen's groups and You! Home health care can result in enormous savings in the long-run".

In its December, 1984 publication, "Mandate for Leadership II," the Heritage Foundation offered as its number one recommendation to the Department of Health and Human Services, "Expand Home Health Services." Said the report, "The keystone of long-term health care policy should be a comprehensive program fostering home care services."

Similarly, former Secretary of Health and Human Services Joseph Califano said in an interview carried in the August 1985 issue of 50 Plus magazine:

> "I think we have to provide the ability for people to stay at home, to grow old at home, to die at home, if they so choose. We have to start paying for home health care in a big way in this country. In the short run, it may cost a little more but in the long run it will save a lot of money."

New York Governor Mario Cuomo says it this way, "At no time in history have the challenges of providing health care been so great. With rising medical costs and tight controls on utilization of hospital beds and services, home health care agencies have gained new stature as an integral part of the health care delivery system."

The obvious question at this point is: Who is opposed to home health care and why?

The answer to this question is: some few people in the Office of Management and Budget (OMB) and in the Department of Health and Human Services.

This report documents a litany of administrative actions designed to undermine and limit the Medicare home health care benefit. Many of these efforts are in direct contravention of the intent of Congress.

This report documents the fact that home health care paradoxically has become the most regulated of American industries. At a time when the airlines, the trucking industry, hospitals and nursing homes are being deregulated, the Department of Health and Human Services has promulgated an oppressive series of requirements applicable to home health agencies.

This report notes that many of the changes being implemented were previously proposed to the Congress and rejected because they were nothing more than bald efforts to cut the Medicare home health benefit. Ironically, the Department has sought to achieve the same effect in administrative edits. Moreover, the Department, in most cases, has not followed the requirements of public notice and comments required by the Administrative Procedure Act. Instead, HHS has implemented these significant changes (and reductions in Medicare benefits) in the guise of new guidelines which it has given the effect of law or regulation. Guidelines are what the name suggests. They have no force of law and yet intermediary insurance companies which pay claims under contract with the Medicare program have been given instructions to enforce the new guidelines as if they were law or regulation, even in cases where the guidelines contradict the regulations currently in effect.

The number of these initiatives aimed at home care providers is significant. Representatives of HHS and its Health Care Financing Administration (HCFA) have talked openly about their desire to curtail home health care because it is the fastest growing part of the Medicare program. They think it is growing at too great a rate.

The contention of this report is that the administrative restrictions placed on home care providers are punitive. They are designed to restrict the statutory Medicare benefit, to force providers out of business or to force them to subsidize Medicare with revenues raised from private contributions of Medicare patients.

There is no question that access to home for Medicare patients is becoming more limited all the time. The results of a questionnaire to all home health agencies in the nation indicate that the great majority felt that the Department was engaged in a campaign not only to keep expenditures for home health at the current

level, but to reduce the level of home health coverage for the elderly. Home care providers and beneficiaries both expressed the belief that the Department for its own reasons has set about the step-by-step dismantling of the Medicare home health benefit. In some cases, these attempts have been blunted by the Congress or by lawsuits brought by the National Association for Home Care (NAHC). But, unless an aroused public and the Congress intervene, the result will be a sharp decrease in the limited home care benefits now available under Medicare rather than the extension of these services to the 5.5 million Americans who currently need such care and are going without it.

II. THE NUMBERS: DEFINITIONS AND PERSPECTIVES

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This section offers statistics and general background about older Americans and the Medicare program. It offers the reader some information about the genesis of the home care benefit in the Medicare Act and its present operation. These statistics and definitions are crucial to understanding the issues in this paper.

A. FACTS ABOUT THE ELDERLY

1. CURRENT POPULATION

The older population -- persons 65 years or older -- numbered 27.4 million in 1983. They represented 11.7% of the U.S. population, about one in every nine Americans. The number of older Americans increased by 1.7 million or 6% since 1980, compared to an increase of 3% for the under-65 population.

In 1983, there were 16.4 million older women and 11.0 million older men, or a sex ratio of 149 women for every 100 men. The sex ratio increased with age, ranging from 124 women to 100 men in the 65-69 age group to a high of 241 women to 100 men, 85 and older.

Since 1900, the percentage of Americans 65+ almost tripled (4.1% in 1900 to 11.7% in 1983). The number increased more than eight times (from 3.1 million to 27.4 million).

The older population itself is getting older. In 1983 the 65-74 age group (16.4 million) was over seven times larger than in 1900, but the 75-84 group (8.5 million) was 11 times larger and the 85+ group (2.5 million) was 20 times larger.

In 1982, persons reaching age 65 had an average life expectancy of an additional 16.8 years (18.8 years for females and 14.4 years for males).

A child born in 1982 could expect to live 74.5 years, about 27 years longer than a child born in 1900. The major part of this increase occurred because of reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 2.5 years since 1960.

About 1.9 million persons celebrated their 65th birthday in 1982 (5,200 per day). In the same year, about 1.4 million persons 65 or older died, resulting in a net increase of over 560,000 (1,550 per day).

2. FUTURE POPULATION

The older population is expected to continue to grow in the future. This growth will slow somewhat during the 1990s because of the relatively small number of babies born during the Great Depression of the 1930s. The most rapid increase is expected between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

By 2030, there will be about 65 million older persons, 2 and one-half times their number in 1980. If current fertility and immigration levels remain stable, the only age groups to experience significant growth in the next century will be those past age 55.

By the year 2000, persons 65+ are expected to represent 13.0% of the population. This percentage may climb to 21.2% by 2030.

3. MARITAL STATUS

In 1983, older men were twice as likely to be married as older women (79% of men, 40% of women).

Half of the older women were widows (50%). There were over five times as many widows (7.7 million) as widowers (1.4 million).

Although divorced older persons represented only 4% of all older persons in 1983, their numbers (nearly one million) had increased four times as fast as the older population as a whole in the preceding 20 years (2.7 times for men, 5.4 times for women).

4. LIVING ARRANGEMENTS

The majority (67%) of older non-institutionalized persons lived in a family setting in 1983. Approximately 8.7 million (82%) older men and 8.7 million (57%) older women, lived with families. The proportion living in a family setting decreased with age. An additional 2% of both men and women, or one-half million older persons, lived with nonrelatives.

About 31% (7.9 million) of all non-institutionalized older persons lived alone (6.2 million women, 1.6 million men). They represented 41% of older women and 15% of older men. Older persons living alone increased in number by 130% between 1963 and 1983, nearly three times the growth rate for the older population in general.

A 1975 study found that 4 of every 5 older persons have children. Of these, 18% lived in the same household with a child and another 55% lived within 30 minutes of a child. Three-fourths (77%) had seen a child within the previous week.

While a small number (1.3 million) and percentage (5%) of the 65+ population lived in institutions (primarily nursing homes) in 1980, the percentage increased dramatically with age, ranging from 2% for persons 65-74 years to 70% for persons 75-84 years and 23% for persons 85+.

5. RACIAL AND ETHNIC COMPOSITION

In 1983, about 90% of persons 65+ were White, 8% Black, and about 1% were other races (including American Eskimo, Asian and Pacific Islanders). Persons of Hispanic origin (who may be of any race) represented 2% of the older population.

6. GEOGRAPHIC DISTRIBUTION

In 1983, about half (45%) of persons 65+ lived in seven states. California and New York had over 2 million each, and Florida, Illinois, Ohio, Pennsylvania, and Texas each had over 1 million.

Persons 65+ constituted 13.0% or more of the total population in eleven states: Florida (17%); Arkansas, Rhode Island, Iowa, Pennsylvania, South Dakota, and Missouri (14% each); and Kansas, Maine, Massachusetts, and Nebraska (13% each).

In twelve states, the 65+ population has grown by more than 10% since 1980: Alaska and Nevada (24% each); Hawaii (17%); Arizona (16%); Idaho, New Mexico, South Carolina, and Utah (12% each); Florida and North Carolina (11% each); and Delaware and Washington (10% each).

Persons 65+ were slightly less likely to live in metropolitan areas in 1980 than younger persons (71% of the elderly, 75% of persons under 65). About 32% of older persons lived in central cities, and 39% lived in suburbs.

The elderly are less likely to change residence than other age groups. In 1980, only 23% of persons 65+ had moved since 1975 (compared to 48% of persons under 65). The majority had moved to another home in the same state.

In 1980, over 1.1 million persons 65+ had moved to a different state since 1975. Of these, over two-fifths (42%) had moved from the Northeast or Midwest region to the South or West (compared to 27% for younger persons) and one-fourth (25%) had moved to Florida (8% for younger persons).

7. INCOME

The median income of older persons in 1983 was $9,766 for males and $5,599 for females. These incomes were 6.3% and 4.4% higher, respectively, than in 1982, but the increases were not statistically significant after adjusting for inflation.

Families headed by persons 65+ reported a median income in 1983 of $16,862 ($17,442 for Whites and $10,438 for Blacks). Nearly one of every four (23%) families with an elderly head had income less than $10,000 and 28% had incomes of $25,000 or more.

Elderly persons living alone or with nonrelatives were likely to have low incomes with half (51%) reporting $7,000 or less. Nearly a third (30%) had incomes under $5,000, while only 17% had $25,000 or more. The median income in 1983 for these individuals was $6,938 ($7,364 for Whites and $4,505 for Blacks).

The major source of income for older families and individuals in 1982 was Social Security (37%), followed by earnings (24%), asset income (23%), public and private pensions (13%), and "transfer" payments such as Supplemental Security, unemployment, and veterans' payments (2%).

Older households were more likely than younger households to have one or more members covered by Medicaid in 1982 (13% vs 9%), but less likely to have received food stamps (6% vs 9%). About one-fourth (22%) of older renter households lived in publicly-owned or subsidized housing (9% for younger renters).

8. POVERTY

About 3.7 million elderly persons were below the poverty level in 1983. The poverty rate for persons 65+ was 14.1%, less than the rate for persons under 65 (15.4%). Another 2.2 million or 8% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level). In total, over one-fifth (22%) of the older population were poor or near-poor in 1983.

One of every eight (12%) elderly Whites was poor, compared to over one-third (36%) of elderly Blacks and about one-fourth (23%) of elderly Hispanics.

Older women had a higher poverty rate (17%) than older men (10%). Likewise, older persons living alone or with nonrelatives were more likely to be poor (26%) than were older persons living in families (8%).

The percent of elderly below the poverty level was higher in non-metropolitan areas (18%) than in metropolitan areas (12%).

The nine states with the highest poverty rates for older persons in 1979 were all in the South: Mississippi (34%); Alabama, Arkansas and Louisiana (28% each); Georgia (26%); South Carolina and Tennessee (25% each); North Carolina (24%); and Kentucky (23%).

9. HOUSING

Of the 17.7 million households headed by older persons in 1983, 75% were owners and 25% were renters. Older male householders were more likely to be owners (83%) than were females (65%).

The housing of older Americans is generally older and less adequate than the balance of the nation's housing. About 40% of the homes owned by older persons in 1980 were built prior to 1940 (22% for younger owners) and 9% were classified as inadequate in 1981 (6% for younger owners).

Households headed by older persons in 1980 spent about the same percentage of their incomes (22%) on housing (excluding maintenance and repair) as did younger households (20%). However, this similarity is due to the larger proportion of older households which own their own home free and clear. The percentage of income spent on housing was higher for older households than for younger households among homeowners without a mortgage (16% vs. 10%), homeowners with a mortgage (26% vs. 19%), and renters (32% vs. 25%).

In 1981, the median value of homes owned by older persons was $44,400 ($28,900 for Blacks and $38,300 for Hispanics). About 84% of older homeowners in 1980 owned their homes free and clear.

10. EMPLOYMENT

About 12% or 3 million older Americans were in the labor force (working or actively seeking work) in 1983, including 1.8 million men and 1.2 million women. They constituted 3% of the U.S. labor force. About 4% of these were unemployed.

Labor force participation of older men has decreased steadily, from about 2 of 3 older men in 1900 to 1 of 6 (17%) in 1983. The participation rate for older females rose slightly from 1 in 12 in 1900 to 1 in 10 during the 1950's, but dropped to 1 in 13 (8%) in 1983.

Approximately half (53%) of the workers over 65 are employed only part-time: 47% of men and 61% of women.

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About 790,000 or 27% of older workers in 1983 were self-employed, compared to 9% for younger workers. Three-fourths of these were men.

11. HEALTH AND HEALTH CARE

In 1981, 30% of older persons assessed their health as fair or poor (compared to 10% for persons under 65). There was little difference between the sexes on this measure, but older Blacks were more likely to rate their health as fair or poor (48%) than were older Whites (29%).

The number of days in which usual activities are restricted because of illness or injury increased with age. Older persons averaged 40 such days in 1981 (38 days for males and 42 days for females, 17 days for younger persons) and both males and females spent all or most of 14 of these days in bed (6 days for younger persons).

The need for functional assistance also increases sharply with age. In 1979-80, about 2.7 million older persons living in the community needed the assistance of another person to perform one or more selected personal care or home management activities. This figure represented 11.5% of non-institutionalized older persons (9% of males, 14% of females), but the percentage ranged from 7% for persons 65-74 to 16% for persons 75-84 and 39% for persons 85+ (31% of males, 44% of females). (Selected personal care activities included bathing, dressing, eating, using the toilet, getting in or out of a bed or chair, or caring for a bowel control device. Selected home management activities included walking or going outside, preparing meals, shopping, routine chores, or handling money. Persons were classified as needing assistance if they needed help from another person to do one or more of these activities, could not do one or more of them at all, or stayed in bed all or most of the time).

Most older persons have at least one chronic condition and many have multiple conditions. The most frequently occurring conditions for the elderly in 1981 were: arthritis (46%), hypertension (38%), hearing impairments and heart conditions (28% each), sinusitis (18%), visual impairments and orthopedic impairments (14% each), arteriosclerosis (10%), and diabetes (8%).

About 18% of older persons were hospitalized during 1981 compared to 9% of persons under 65. The elderly were more likely than younger persons to have more than one hospital stay per year and to stay in the hospital longer (10 days vs. 7 days). Older persons also averaged more visits to doctors in 1981 than did persons under 65 (6 visits vs. 4 visits).

In 1984 the 65+ group is projected to represent 12% of the U.S. population but account for 31% of total personal health care expenditures. These expenditures are expected to total $120 billion and to average $4,202 per year for each older person, more than 3 times the $1,300 spent for younger persons. About $1,000 or one-fourth of the average expenditures is expected to come from direct ("out-of-pocket") payments by or for older persons.

Health care costs in America have been expanding at about 10 percent a year and are now approaching 10 percent of the entire Gross National Product. In 1984, Americans spent $387.4 billion for health care. The largest single expenditure was $258 billion paid for hospital care. Nursing homes received about $32

billion. Expenditures for home health services are small by comparison to either of the above and are estimated at some $3.3 billion in the same year. The latter figure does not include another $3 billion in durable medical equipment and supplies provided to clients in their homes.

The Federal government paid for about 30 percent of the total through Medicare ($63 billion) and Medicaid ($19.7 billion), the latter being a state matching program with a grand total of some $40 billion in expenditures.

The Federal government spent something like $100 billion for health care in 1984. Private health insurance paid 31% of the total, or some $107 billion. Consumers picked up an additional 28% ($95.4 billion) out of their own pockets and state and local governments paid 10% of the bill.

Home health expenditures still constitute a tiny part of either Medicare or Medicaid programs.

In 1984 only some $600 million was paid for home care by the Medicaid program. New York State alone accounted for more than half of all national expenditures. This is true in spite of a requirement that all states offer home care coverage under this program.

Home health expenditures constituted some 3.1% of the Medicare program in 1984, increasing only two percentage points since 1971. In 1971, home health care made up only 1% of Medicare expenditures.

There are some 31 million Americans eligible for Medicare, but only about 1.2 million utilize home health services in any given year.

The average Medicare home visit cost $42 in 1984 as compared to $62 a day for a nursing home and about $300 a day in a hospital.

Medicare paid about $40 billion for hospital care in 1984, about $15 billion for physicians' services, and only about $2 billion for home health care.

BACKGROUND AND HISTORY OF HOME HEALTH BENEFITS UNDER MEDICARE

Home health benefits were included in the Medicare law as originally enacted in 1965, based on a limited experience. These services were not generally available at that time, nor were they normally included in private insurance coverage.

Home health benefits were included in the Medicare benefit structure on the recommendation of medical care experts to provide benefits of particular advantage to older persons who may often need lower levels of intensity of care than is provided in hospitals for extended periods and who prefer to receive these services in the familiar surroundings of their homes. Experts also expected that home care would improve the efficiencies with which Medicare services were provided by reducing the need for hospital or nursing home institutional services. Medicare legislation provided for the coverage of home health services, but because of the absence of experience with such coverage and the risk involved, policymakers could not predict--in the beginning-- how the service would grow and change once coverage occurred. As a result, the 1965 law set out a number of conditions applying to the coverage of home health services. These limitations included the following:

1. Home health benefits under the Hospital Insurance (Part A) portion of Medicare were available only after a prior hospital stay of three or more days.

2. Benefits under the Supplementary Medical Insurance (Part B) portion of the program were subject to an annual deductible and 20% coinsurance payment for covered services.

3. The number of covered home care visits was limited to 100 visits per benefit period within a year after hospital discharge under Part A and 100 visits during a calendar year under Part B.

4. Home health services had to be ordered by a physician and provided under a plan developed by the physician.

5. The patient had to be homebound.

6. For coverage to be available, nursing services or physical or speech therapy had to be needed on an intermittent basis.

7. Home health aide services could be provided on a part-time or intermittent basis, but only to the extent permitted by regulations.

8. Services provided had to be reasonable and necessary for diagnosis or treatment.

9. Investor-owned agencies (of which there were none at the time of enactment) could participate only if licensed (few states licensed home health agencies at that time).

Many of these limitations on home health services are matters which were subject to considerable administrative discretion, expressing the need for flexibility related to limited experience and availability of home health services. At the program's beginning, much of this leeway was given over to the fiscal intermediaries, which contract with the Federal government to administer Medicare, and it was generally argued that the intermediaries' interpretations of law and regulation were liberal in allowing coverage. Furthermore, the Department (Health, Education and Welfare at the time) strongly supported efforts to increase the number of home health agencies and to strengthen existing agencies to assure that home health services would actually be widely available to the elderly. As a result of these two factors, expenditures on home health services in the first few years, from 1966-1969, increased very rapidly, as shown in Table 1.

TABLE 1

AMOUNT REIMBURSED BY MEDICARE

for

HOME HEALTH SERVICES

1966-1985

(millions)

1966*	$ 3	1976	$ 295
1967	46	1977	366
1968	67	1978	427
1969	78	1979	518
1970	62	1980	662
1971	57	1981	814
1972	66	1982	1,091
1973	93	1983	1,369
1974	144	1984	2,016
1975	217	1985	2,233

* Expenditures in 1966 represented coverage for only part of the year and reflected delays in the initial payment process.

Expenditures rose sharply from $46 million in 1967 -- the first full year of operation--to $78 million in 1969, an increase of almost 70% in two years. Subsequently, however, largely because of coverage policy changes adopted by Medicare program managers, expenditures actually declined in 1970 and remained at low levels until 1972, after which a continuing, quite rapid increase in expenditures again occurred unabated through 1985.

The large annual increases in home health expenditures over the last 10 years have been due, in part, to expansion in the number of people covered by Medicare (including the disabled in 1972) and, in part, to a liberalization of benefits for home health services (particularly by legislative action in 1980). Legislative changes adopted in 1980 eliminated the application of the three-day hospital stay requirement and the deductible and coinsurance provisions as they applied to home health benefits under both parts of Medicare. Also eliminated was the limit on the maximum number of visits covered by the program, and the special licensing requirements applied to investor-owned agencies. Another factor, of course, is the impetus of the prospective payment (DRG) reimbursement system for Medicare participating hospitals.

While some of the coverage limitations were removed over the years, other kinds of restrictions were being applied to Medicare reimbursement rules for home health services. Reimbursement for home health services continued to be computed on a retroactive, reasonable cost basis, but costs were subject to certain limits. These limits--applied since 1979 under legislative authority enacted in 1972--put ceilings on the average costs per visit of the home health agencies payable by the Medicare program. New cost limits announced for the year beginning July, 1985, now provide for separate ceilings on the average costs for <u>each</u> home health discipline rather than for an average of the combined costs of <u>different</u> types of home health services as had applied previously.

The current cost limits on home health care imposed controls only on costs per visit. The number of visits provided has, in fact, been increasing substantially faster than the costs per visit. This increase in the volume of home health visits is primarily due to the larger numbers of people being served.

Capacity to provide home care has increased to match the demand for the service. A major element in the capacity increase has been a large growth in the number of home health agencies since 1980.

As a result of all these factors, while the actual average number of visits per person served has been relatively stable in recent years -- increasing only slightly -- the total expenditures for home health care have substantially increased (from 1% of the program in 1971 to 3% in 1985). Data on persons served, visits, and charges per visit are shown in Table 2.

Table 2

Medicare: Utilization of Home Health Services,
Selected Calendar Years 1975-1984

Calendar Year	Persons Served (in thousands)	Home Health Visits (in millions)	Visits Per 1,000 Enrollees	Visits Per Person Served	Average Charge Per Visit
1975	500	10.8	431	21.6	$ 20
1977	700	15.8	597	22.5	25
1979	870	20.0	717	22.9	30
1980	960	22.6	792	23.4	33
1981	1,080	26.2	902	24.3	36
1982	1,190	31.3	1,060	26.3	40
1983	1,380	37.6	1,252	27.3	43
1984 (E)	1,450	40.5	1,330	28.0	46
Annual Percentage Increase					
1975-1983	13.5	16.9	14.3	3.0	10.0
1983-1984	5.1	7.7	6.2	2.6	7.0

E=estimate

Source: Health Care Spending Bulletin, 85-04

BENEFITS PROVIDED

The services now covered by Medicare as home health services include the following:

1. Part-time or intermittent nursing care;

2. Physical, occupational, or speech therapy;

3. Medical social services;

4. To the extent permitted in regulations, part-time or intermittent services of a home health aide;

5. Medical services of interns and residents under an approved teaching program of a hospital with which the agency is affiliated; and,

6. The foregoing services furnished on an outpatient basis at a hospital, skilled nursing facility, or rehabilitation center, under arrangements made by the home health agency, involving equipment that cannot readily be made available at the patient's residence.

The home health services covered in practice depend also on certain other limitations applied by law, regulation, and administrative policies relating to their coverage. The limitations applied by law to coverage were discussed above. Among the regulatory and manual directions that are of particular significance to home health benefits are the rules related to: (1) the homebound requirement; (2) the definition of "part-time or intermittent" services; (3) the rules for determining whether a "skilled" nursing service is required; (4) the extent to which services by a home health aide may be covered; and, (5) the basis for determining the degree to which home health services are reasonable and medically necessary.

1. To be considered homebound, a patient is expected to have a normal inability to leave home so that leaving, if possible at all, would require a considerable and taxing effort. The basic issue that underlies the finding as to whether the patient is homebound is whether or not the patient has the capacity to obtain the health care needed outside of, rather than in, the home. The Medicare manuals cite a number of examples that indicate when a patient is to be considered homebound, as well as citing cases where absences from the home would not constitute indications that the patient has the capacity to obtain the care outside the home. For example, occasional walks around the block or a drive do not indicate the patient is not homebound. Generally, the patient is said to be considered homebound, for example, if he requires canes, crutches, wheelchair, a walker, or assistance of another person to leave the home. While the definition of homebound would not appear to be very restrictive, a HCFA 1984 study found that about 1% of home visits were being provided to persons the staff did not find to be homebound. Furthermore, in a 1981 report, the GAO cited the term, "homebound," as being insufficently defined or documented in home health claims.

2. Part-time or intermittent service is said to usually mean service for a few hours a day several times a week. Eight hours of service may be covered for a limited period when neither part-time home care nor institutionalization

is feasible. Intermittent care usually means a recurring need for care at least once in sixty days. Less frequently needed care is not covered. Part-time care will be paid for seven days a week when needed for a short period of time (two to three weeks and sometimes longer if special conditions--e.g., relapse or terminal care--warrant). When more frequent care is provided than would be covered by HCFA rules, the agency is asked to report the total care and not to bill for only the level that would be covered. If the total would be non-covered because it is too continuous, no payment is made for any part of the care.

3. In determining whether skilled nursing care is required, consideration is given to both the inherent complexity of the service to be provided and the condition of the patient. When a service can be safely and effectively performed by the average non-medical person without the direct supervision of a licensed nurse, the service cannot be regarded as skilled. Observation and evaluation may be considered a skilled service, as may be teaching and training activities, supervisory activities, therapeutic exercises, insertion and irrigation of a catheter, intravenous and intramuscular injections, and treatment of extensive decubitus ulcers.

4. The primary function of a home health aide is personal care, which may be covered when skilled services are also needed. The home health aide may also perform certain incidental household services to prevent or postpone institutionalization, which may be covered if they do not materially increase the time required for the visit and the visit is required to deliver covered health services. If the time for the visit is materially increased by the household services, they are not reimbursable. The home health aide provisions are the only ones under which non-health home care services may be covered.

5. No home health services are covered unless skilled nursing or physical or speech therapy is required, and home health services must be reasonable and necessary for the treatment of illness or injury of the patient. Preventive services are not covered. Observation and evaluation of the patient's condition is covered only when a reasonable probability exists that significant changes in condition may occur that would require skill to evaluate for indication of a need for a change in treatment. Sometimes a home service has been considered not reasonable and necessary because it is considered too complex to be delivered in the home setting. In other cases, the services may cease to be covered as no longer necessary because the patient's condition has changed to the point that services are no longer needed.

The preceding five points are the ratchets which have been used by the Department of Health and Human Services to tighten eligibility for home care services. By tightening the ratchets, DHHS has restricted the availability of services mandated by law and increasingly placed home health agencies in the position of rendering services to clients eligible for Medicare upon physicians' orders only to be told that the care is non-covered and that they will not be paid for their work.

Home health agencies are told that individuals do not qualify because they are not sick enough (they do not meet the arbitrary test of "skilled nursing care"). They have also been told that the patient is too sick (does not meet the test of "intermittent care") and that they should have known better than to try to render care for individuals who really belong in a nursing home.

They have been told that patients do not qualify because the care was not reasonable and necessary, and yet their own medical judgment and that of the patient's physician was that the care was necessary--perhaps even vital to the well being of the client.

They have been told that they cannot be paid for care rendered to clients because the clients have mobility (they were not homebound). The paradox is that Medicare and medical ethics demand that the agency do everything in its power to restore mobility to the client, yet they will be barred from reimbursement if they succeed. More and more, the term "homebound" has been interpreted to mean "bedbound." This unfortunate development is completely out of sync with Congressional intent as expressed in law and regulations.

In addition, the fact that Medicare contracts with various intermediary insurance companies to adjudicate and pay claims and, therefter, to audit providers has led also to enormous inconsistency. Patients with an identical diagnosis have been (a) denied care because they were too sick, (b) denied care because they were not sick enough and, (c) accepted and paid for by Medicare. In all instances, the home health agencies in question were providing the service ordered by a physician.

III. THE NEED: THE GROWING CARE GAP

III. THE NEED: THE GROWING CARE GAP

The United States is generally regarded as having one of the best systems of medical care in the world. It is also one of the most expensive. There are few who would criticize the quality of care, but there are many experts who would challenge the efficiency of the system.

It is a peculiar paradox that the blessings of the unique American system of medicine do not fall evenly on the entire population.

It is a shock to most people to learn that epidemics still run unchecked in certain parts of America. There are places in America where infant mortality is as high as in less developed nations. There are areas where mothers have no health care prior to birth, where children, if they survive, are raised without benefit of the finest system of medicine the world has yet seen.

It is hard to understand such poverty in the midst of the bountiful blessing which this nation affords.

The same can be said of the problems which confront the nation's older Americans. The elderly have been helped immeasurably by Medicare. It is the rock that they lean upon, and yet that rock has developed numerous wide fissures, and there is real concern among the elderly that it will either crumble or be taken out from under them.

There are other groups, of course, who are going without the medical care that they need: the handicapped and disabled, for example, and the mentally impaired for another.

It is the growing gaps in America's health care system which continually lead to discussions of the desirability of enacting some kind of national health insurance plan.

It was the gaps in the existing system in the early 1960's which was the principal reason that Congress chose to enact the Medicare program.

Congress stated the principle that ability to pay should have nothing to do with access to the highest quality health care available. The principle was central to Medicare. The law was a reaction against the abhorrent two-class system of medicine which existed at the time: one for those who could pay, and another for those who could not.

To this day, serious gaps remain in the health care system. It can be argued that the gaps today are wider than they have been at any time since the enactment of Medicare. For example:

- In 1985, the Foundation for Hospice and Homecare estimated that many of the 10 million children with birth defects or related problems were either going without needed care or alternatively, were unnecessarily institutionalized.

- In 1984, the Urban Institute estimated that about 20 percent of the American public was without any form of health insurance.

- In 1985, the Medicare program still only covered about 38 percent of the health care expenditures of older Americans. There are tremendous gaps in that coverage: There is no coverage for eyeglasses, hearing aids, dental care, out-of-hospital prescription drugs, extremely limited coverage of home health care, and virtually no coverage for long-term care either offered through home health agencies or nursing homes. The mental health coverage of Medicare is also nothing to brag about.

- Even though Medicare by law provides health care coverage for the disabled, the definition of disability is so limited that few actually qualify.

- The quality and the availability of health care to the armed forces and veterans have recently been under fire. The charges include both lack of coverage and inappropriate utilization.

Employers, unions, private health insurance companies and government have all expressed grave concern about the growing gaps in the American health care system. Irony compounds irony because these developments have occurred at a time when budget constraints have sharply limited what each of these entities can do to provide health care to all those who need it.

Given the limitation on dollars, the search has moved in the direction of cost containment and greater efficiency. Greater efficiency, it is argued, would save money and perhaps even free up enough of it to actually extend benefits.

The Reagan Administration has turned to competition and unleashing of the free market forces with the thought that this will force prices down. With lower costs, more services can be provided for the same dollar.

LONG-TERM CARE

The one area which is most troubling is long-term care. The fastest growing age group in America is that over age 85. Americans who live to this age and beyond will inevitably suffer from multiple disabilities. These problems tend to be complex and chronic in nature. As more and more Americans reach this plateau in life, the need for long-term care services will become all the more acute.

The present system of health care is geared towards acute care. Understandably, physicians seem to be more interested in acute problems where some dramatic cure is possible than in chronic problems which persist from day to day.

The American policy towards long-term chronic disease is neglect or abandonment. The only answer to the long-term care dilemma at the present time is nursing home placement. But this, too, is only available (a) to the very rich who can pay their own way, or (b) to the very poor who have exhausted their income and assets and are willing to take the pauper's oath and become wards of the State.

Prior to the enactment of Medicare, many home health agencies provided long-term care, taking care of patients on an intermittent basis in their own homes off and on for years at a time. The funds to make this possible were raised privately. Medicare changed all of that, and home care became molded in the image of Medicare with its emphasis on acute care. To be sure, many home care agencies still provide long-term care, but it is increasingly becoming a struggle to do so.

There are also increasing pressures on industry to cover long-term care on behalf of their employees. These pressures are amplified because of the growing cost of health care and the need for cost containment. The dilemma: how to extend coverage for long-term care and reduce costs at the same time. It is obvious that home care is the solution to the dilemma.

COST CONTAINMENT PLACES PRESSURES ON INSTITUTIONAL CARE

What we are witnessing today is an increasing trend for the gap in unmet health care needs to widen because the pressures of health care cost containment are reducing access and entry to institutional care without a corresponding adjustment in coverage policies for home care and other non-institutional care to cover services which were either previously covered in institutions or never covered at all. The three main pressures have been: the development of prospective payment systems applicable to inpatient hospital and nursing home care; the development of more restrictive private business and private health insurer policies for covering institutional care; and increasing state limits on the expansion of skilled nursing home and intermediary care facility bed capacity.

Let's look at each of these factors. First is the development of prospective payment-type systems. In 1983 Congress passed legislation (P.L. 98-21) phasing-in over four years (effective October 1, 1983) a prospective payment system for inpatient hospital services under the Medicare program. This system, called DRGs (Diagnosis Related Groups), replaced the previous cost-based reimbursement system which had resulted in $33 billion in Medicare outlays in FY 1982 (66 percent of the total Medicare Budget) - compared to 2.4 percent for home care. The Medicare DRG system was a late development in the overall move by government health care payors away from the cost-based system to some variety of predictable, fixed payment system. At least four states prior to 1983 had implemented a prospective payment-type system for all payors for inpatient hospital care, including Medicare (New York, New Jersey, Maryland and Massachusetts). And, as of 1980, the General Accounting Office (GAO) reported that 33 states had a prospective payment type system for their Medicaid nursing home program. As of early 1985, HCFA was still in the midst of a project to develop a prospective payment system for Medicare SNF payment. And the trend continues. As of the end of 1984, several states either had adopted, or had committed to adopt, a Medicare DRG type payment system for the Medicaid inpatient hospital program (Michigan, Pennsylvania, Ohio, Minnesota). And as of late 1984, several private insurers announced new programs modeled after the Medicare DRG program as the basis for their reimbursement of inpatient hospital care (Blue Cross Plans in Kansas, Oklahoma, Iowa, Arizona and Nebraska; pilots are underway in Blue Cross Plans in Florida and Michigan).

Second is the one development of more restrictive private business and private health insurer policies for covering institutional care as well as the development of programs to encourage non-institutional care. For example:

(1) The U.S. Chamber of Commerce reports 150 employer coalitions to contain health care costs.

(2) The consulting firm of William M. Mercer, Inc. found in a 1984 survey of 1,420 companies that 42 percent of the respondents with 10,000 employees or more have plans to develop health care management strategies.

(3) The Midwest Business Group on Health in March 1984 found in a survey of 64 companies representing over 1 million employees in an 8 state area:

* 52 companies have implemented extended care facility benefits, 10 of these with no requirement for prior hospital stay.

* 49 have implemented or planned home care; 18 are considering it.

* 72% have expanded out-patient surgery benefits and 38% implemented greater reimbursement than available as an in-patient.

* 16 have or will be paying for birthing centers, a relatively new concept; 35 have interest.

* Hospice care has already been implemented by about 25% of those responding; nearly half expressed interest.

(4) Blue Cross/Blue Shield of Maryland has reported a savings of $1.2 million in 1982 from its Coordinated Home Care Program, largely by reducing the average subscriber's inpatient day stays by 8.9 days. Since 1973 the Blue Cross program has reported a net savings of $6.3 million for the program.

(5) Aetna Life and Casualty has reported an average savings of $60,000 per case from its Individual Care Management Program by using home care for victims of catastrophic accidents and illnesses.

(6) At least fifteen Blue Cross and Blue Shield Plans now offer programs to encourage early maternity discharges to home care. Blue Cross estimates that if only one-half day were cut from the average 3-day normal delivery stay there would be a $40-$50 million annual savings in hospital costs.

(7) In July 1985, the Blue Cross and Blue Shield Association reported that 90 percent of their plans have home health coverage.

(8) In June 1985, the U.S. Bureau of the Census reported that 46 percent of all health insurance plans of medium and large firms have home health coverage and 11 percent have hospice coverage.

A recent survey of Fortune 500 companies found that ambulatory surgery programs, used by 82 percent of the respondents, ranks first among 15 different strategies identified by business as a means to control healthcare costs; wellness programs, on the other hand, were ranked last in importance as a cost containment strategy. Home care ranked seventh. The survey was conducted in January 1985 by PULSE Measurement Systems (Indianapolis, Ind.) and Hospitals Magazine.

According to the survey, U.S. business has apparently embraced alternate healthcare delivery systems, such as ambulatory surgery and outpatient testing, as more important strategies for reducing healthcare expenditures than participation in business coalitions of representation on hospital boards. The eight approaches considered most important are, in descending order, ambulatory surgery, preadmission testing, greater cost sharing with employees, self-insurance programs, utilization review programs, second opinion programs, home healthcare, and preadmission review.

The survey concludes that business is also showing greater interest in PPOs (Preferred Provider Organizations), which were cited as having the greatest growth potential among alternate delivery systems. In 1983, only 6 percent of the respondents said they offered a PPO option to their employees. By 1984, that number had risen to 16 percent and in 1985, 30 percent of all companies surveyed expect to offer a PPO option.

While business is looking optimistically at PPOs, it seems less enthusiastic about HMOs. The survey found that while 82 percent of the companies offer their employees an HMO plan, those same companies rate HMOs only of average importance as a strategy for fighting rising healthcare costs. And, though the number of companies offering HMOs had steadily grown, this year fewer companies (by three percent) say they will offer HMO plans. Employees, however, seem to like HMOs; HMO enrollment among employees is up, and the percentage of companies with more than 30 percent of employees enrolled in HMOs has grown.

Other findings of the survey include:

- o Of the almost three-quarters of all companies that have second opinion programs, 50 percent require employees to use the program before elective surgery, and 64 percent have a penalty associated with an employee's failure to secure a second opinion prior to elective surgery.

- o In 1984, 67 percent of 109 unionized companies negotiated a contract with one or more of their unions. During these negotiations, health benefit additions resulted 36 percent of the time, while deletions resulted only 19 percent of the time. However, coinsurance amounts required from employees were raised in 41 percent of the negotiations.

- O Eighty percent of the companies surveyed self-insure, the most frequently implemented non-provider cost containment strategy.

- o Corporate medical directors, "arguably the most direct method to control costs because it places business in the realm of delivery," operate in the majority of the companies surveyed.

Third, is the increase of state limits on the expansion of skilled nursing home and intermediate care facility bed capacity. For example:

- * A 1983 GAO report (GAO/IPE-84-1) found 12 states which had limited the ability to have additional SNF beds constructed.

- * A 1984 report by the Intergovernmental Health Policy Project (of George Washington University, Washington, D.C.) reported 1983 legislation to limit ICF and/or nursing home bed construction in the states of North Carolina, Missouri, Minnesota and Kentucky. (IHHP, State Health Notes, No. 39, October-November 1983).

An important caveat here is that there still are some states which have not limited the capacity for skilled nursing home and/or intermediate care facility growth and have not instituted a prospective payment or other types of limits on payments. Medicaid accounted for $13 billion for all nursing home costs in the nation. In addition, about 33 percent of all Medicaid expenditures are for SNFs compared to 1.7 percent for home care.

Overall, available data indicates that fewer Americans seeking health care seem to choose a hospital as their first option than in prior years or, if they do, their length of stay is substantially less. The American Hospital Association (AHA) cites the effort to contain institutional care costs as a major reason for declining hospital bed occupancy rates and lengths of stay. Other studies corroborate the AHA data in analyzing the increasing number of hospitals experiencing or expecting to experience "financial distress."

And despite all this pressure to constrain the cost of institutional health care, it is still expected that institutional costs will account for about 98 percent of all national health care expenditures in 1995 compared to 2 percent for home care services and product expenditures.

A number of studies predict the trend toward non-institutional care will continue. For instance, a July 1984 study by Arthur Andersen and Company and the American College of Hospital Administrators ("Health Care in the 1990s: Trends and Strategies") found:

- In 1982, 87 percent of all hospital care was rendered on an inpatient basis and 13 percent on an outpatient basis. By 1990, it is projected the balance will shift to 80 percent inpatient and 20 percent outpatient; by 1995 the distribution is predicted to be 75 percent inpatient and 25 percent outpatient.

- Acute care hospital admissions were at 170 per 1,000 population in 1982 and are projected to drop to 165/1,000 population in 1990 and to 160/1,000 population in 1995.

- Average hospital length of stay was at 7.6 days in 1982 and is projected to drop to 7.0 by 1990 and 6.5 by 1995.

A 1985 survey of 125 health policy experts by the Health Insurance Association of America ("The Health Care System in the Mid-1990s") found the following projected trends:

- Hospitals combining services to offer "totally integrated health care systems",

- HMOs and other alternate delivery systems will experience "explosive" growth,

- Care will continue to shift from inpatient to ambulatory settings, with physicians joining group practices,

- Health insurers will emphasize beneficiary cost-sharing and offer multi-option benefit plans.

Additionally, large chain health care providers are moving quickly to become integrated health care providers (see July 1984 CARING magazine), including offering their own insurance plans. As of July 1985 Humana, American Medical International (AMI), Hospital Corporatin of America (HCA), National Medical Enterprises (NME), and Voluntary Hospitals Association (in conjunction with Aetna) already had initiated their own health insurance plans.

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There are several results of these cost containment pressures:

- o Some persons are receiving no health care.

- o Some persons are receiving hospital inpatient care but being discharged on a legitimate medical basis "sicker and quicker" with either no follow-up or only limited follow-up care available. Some are too sick to qualify for the limited Medicare or other "intermittent" home care benefits and either go directly to a nursing home or get re-admitted immediately to a hospital; and still others stay at home without appropriate follow-up care with their condition deteriorating so as to force them to re-enter a hospital or go to a nursing home.

- o Some are literally "dumped" into the community to fend for themselves.

The question becomes, where do Americans go who previously were receiving hospital inpatient care and how has our health care system adjusted its coverage and payment policies to accommodate the need it has helped foster for more non-institutional care. Some are turning more to self-care; some are turning to "alternative" service sources (home care, wellness centers, occupational health, birthing centers, primary care centers, rehab centers, ambulatory care, urgent centers, etc.); and some are turning to skilled nursing homes.

FAILURE TO ADJUST NON-INSTITUTIONAL HEALTH CARE COVERAGE AND PAYMENT POLICIES

While government and private health insurers are increasing the pressure to reduce institutional health care costs by more restrictive coverage and payment policies, these insurers have not simultaneously initiated adjustments in their coverage and payment policies for non-institutional health care sufficient to allow reimbursable coverage of care needed by large segments of the population. Some of this uncovered but needed care pre-dates the recent pressures to contain institutional costs and has been increased by the pressure of cost containment. Other uncovered but needed care has been created directly by the cost containment pressures limiting or eliminating care previously reimbursable in institutional settings.

The current limits in coverage and reimbursement policies for home care are a prime illustration of the gap in needed care. Government and private insurer policies for home care coverage and reimbursement simply have not adapted to cover either the historical unmet care need or the new unmet care need being created by the pressures on institutional health care cost containment.

The best way to understand the nature and extent of gaps in care as related to home care is to look at the two major categories of home care patients and care. The first category is acute care patients. These are persons who after a short, and often intense, period of treatment and rehabilitation at home usually will no longer need such services, or may need a periodic short re-entry to home care.

The second category is for chronic or long-term patients. These patients usually require a longer period of treatment and often a wider range of services in order to maintain a minimal level of function so as to avoid institutionalization (or to limit the length of medically necessary institutional care). These two categories of patients differ not only in the nature of the patients themselves, but the services needed and methods of payment.

ACUTE HOME CARE

Acute home care usually involves skilled care (usually nurses and therapists) for a relatively short time to help the patient achieve rehabilitation, recuperation or recovery of independent function. These patients usually require some type of intense follow-up care for several weeks or months after discharge from an acute care hospital. Types of patients amenable to acute home care include:

- Persons requiring respiratory therapy, chemotherapy, antibiotic therapy, enteral/parenteral nutritional therapy, other intravenous therapies and hemodialysis. In such cases, care which would have required initial and/or ongoing hospitalization can be provided at home usually by some combination of a physician, nurse or trained home health aide.

- Persons recuperating from general medical and surgical care hospitalization whose inpatient stays may be significantly shortened by use of home care services,

- Persons who were hospitalized for a disabling condition (i.e., stroke, hip fracture) who can receive little, if any, added benefit from inpatient care, but need continued intensive short-term rehabilitation services (to regain functional independence) which can be provided at home. Without home care, such persons may be forced to re-enter the hosptial or enter a nursing home.

- Terminally ill patients.

Acute home care patients usually require mainly skilled care delivered by nurses and therapists. The nature and amount of supportive services (home health aides and/or homemakers) will depend on the nature of the functional impairment and the availability and capability of the patient's personal support system (i.e., spouse, parent, child, relatives, friends).

Most payment systems which cover home care focus almost exclusively on services for acute home care patients. Medicare, the largest payor for such services ($1.5 billion in FY 1982) covers only "intermittent" skilled nursing or "intermittent" home health aide care, limited medical social service, and limited physical, speech and occupational therapy. However, Medicare has specific eligibility and coverage criteria which limit the nature and extent of acute care. First, the patient must be "homebound," except for short and infrequent trips outside the home for medical, and to some extent, non-medical reasons. Due to the latitude given private fiscal intermediaries (who process claims for Medicare) in interpreting "homebound" status, patients who require acute homecare often are denied initial eligibility for home care. In other cases, patients are initially deemed eligible but are later deemed "not homebound" because the intermediary believes the patient has acquired too much mobility (often as a result of the physician-prescribed rehabilitative acute home care). And in still other cases, patients receiving outpatient chemotherapy or hemodialysis may be deemed "not homebound" because the intermediary feels they are leaving the home too frequently.

A second limit on eligibility for Medicare home health is that only intermittment skilled nursing services, physical or speech therapy are qualifying need criteria. The need for occupational therapy is not a qualifying criterion for initial care, while it is a qualifying criterion for continuing care. This excludes yet another group of persons requiring home care.

Another Medicare limit on acute home care is that the care can only be "intermittent" skilled nursing and "intermittent" home health aide care. The "intermittent" requirement similarly is subject to varying and inconsistent interpretations by fiscal intermediaries which can and do restrict the number of visits per day, number of days per week, and number of weeks total of Medicare covered home care a person may receive. A third Medicare limit is that of "skilled nursing" which similarly has varying and often restrictive interpretations by fiscal intermediaries. For instance, in some cases an intermediary will deny reimbursement for nursing visits by saying the specific care was not "skilled" and should have been done by an aide or family member. Those types of medical judgments by the intermediary often can run counter to physician orders, State Nurse Practice Acts, and/or accepted nursing practices.

The basic Medicaid home health benefit, which paid about $500 million for home health care in FY 1982, also covers only acute home care and has the same limiting eligibility and coverage definitions as Medicare. In addition, the Federal Medicaid statute does not require that states cover physical, speech and occupational therapy. And states may (and many do) add further restrictions on eligibility, coverage and reimbursement. Some states have expanded their Medicaid coverage (to additional populations like the non-elderly, mentally retarded, developmentally disabled) and services (e.g., by applying for a Medicaid 2176 waiver).

Most private third party payors (such as Blue Cross Plans and the commercial carriers) increasingly provide some type of coverage of home care services in their basic policies. One reason is the cost containment aspect of home care. Another is that 17 states now require that private insurers must have home care coverage in their policies. The state requirements, however, usually are limited in the nature and extent of required coverage. Private insurance generally tends to be restrictive with benefits usually either at the same level as Medicare or frequently less comprehensive in scope and payment than Medicare. In most cases, private insurance standard policy coverage is limited to skilled care services on an acute basis to patients following acute hospitalization (i.e., a prior hospitalization requirement - something Medicare dropped in 1980). Thus, standard private insurance home care coverage provides little, if any, additional coverage to persons over 65 years of age and gives persons under age 65 only Medicare-type acute home care coverage or less.

In addition to standard policy coverage of acute home care, some private health insurers have developed additional programs giving coverage for home care services for specific situations (catastrophic illness or accidents, maternity care) tied to decreased inpatient care. Medigap policies, designed to supplement Medicare, are structured to give Medicare patients assistance in meeting deductible and copayment requirements and do not supplement coverage of actual home or other services.

LONG TERM AND CHRONIC HOME CARE

Long term care often is associated only with skilled nursing homes. This is primarily because payors orient their reimbursement for long term care to nursing homes. Contrary to the current payment practices, there is a need for a capability to deliver long term care at home. Long term and chronic home care delivery applies to several types of patients:

- Persons who suffer a severe injury or illness (i.e., trauma) who require long-term (over a period of months to several years) rehabilitation therapy with a combination of skilled and supportive services at home.

- Persons with chronic disabling conditions (i.e., multiple sclerosis, severe diabetes, Alzheimer's disease, partial or complete paralysis and various conditions causing ventilator dependency) who require long term skilled care and supported services. Unless home care is available to such persons with severe disabilities, they have no alternative other than institutionalization.

- Elderly persons in particular with significantly reduced levels of function and/or mobility requiring long term skilled care and supportive services in order to avoid nursing home placement. A study by the NCHSR found that in 1977, chronic health conditions limited the activities of about 10 percent of the U.S. population.

- Selected terminally ill patients.

Persons amenable to chronic home care utilize both skilled and supportive services, but their greatest need tends to be for supportive personal care services (i.e., home health aides, homemakers, chore services, meals-on-wheels, etc.). The availability and capability of spouses, parents, children or other relatives will determine the nature and extent to which professional supportive services are needed. Even where capable personal family/relative/friend support is available, some relief (such as respite care or day care) often is desirable if the familial caregiver is employed or just to provide relief from the physical and mental stress of rendering care. Neither Medicare, Medicaid nor most private insurers cover either respite or day care.

In general, there are few payment mechanisms which support chronic home care patients. In some cases there may be some form of long-term disability coverage available through an employer or a special private health insurer program. Many private insurers are exploring the possibility of long term care insurance and a few have policies in place, some of which cover home care.

Persons needing chronic home care usually cannot even receive acute home care because they are determined to need more care than merely "intermittent" care. As a result, persons needing chronic care often seek re-admission to hospitals and many ultimately end up in nursing homes. In order to qualify for nursing home care many patients and their families "spend down" their resources in order to reach Medicaid eligibility levels.

Terminally ill persons have received increased coverage for various forms of "hospice care" from major private insurers in recent years. One survey indicated that as of October 1983, 13 major private insurers had some form of hospice coverage in their standard policies. The increased use of hospice coverage is due in large part to studies showing significant reductions in inpatient care cost for terminally ill persons when hospice care is a covered service. Medicare added a limited hospice benefit, effective for a three year period beginning November 1, 1983. The availability of Medicare hospice coverage has been limited due to the reluctance of many providers to participate due to reimbursment limits and due to excessive administrative requirements.

OTHER POPULATIONS

In addition to the acute and chronic care populations, there are other populations which have limited, if any, access to home care. Some of these are populations defined by non-diagnostic characteristics and others have a diagnostic basis.

One major category is the under 65 years of age population and, within this population, children. Medicare does not cover persons under 65 years of age, and the limited Medicaid home care benefit applies only to those who qualify on a means-tested basis. Private insurers, as noted above, provide limited acute home care coverage and it's usually equivalent to Medicare coverage or less. This is despite a demonstrated need for home care. For instance, despite the limited availability of government and private payment mechanisms, nearly 20 percent of all home care patients in New York City are less than 65 years of age. And studies by the American Association for Respiratory Therapy and others have demonstrated both the need and cost-effectiveness of home care for ventilator-dependent children (and ventilator-dependent persons generally).

There also are both limited access to, and limited payment sources available for, even acute home care for veterans, American Indians and Alaskan natives and certain other ethnic minorities. In addition there are persons with substance abuse, mental health, or communicable disease problems, e.g., AIDS, who have little, if any, access to reimbursable home care services.

The drive to contain excessive institutional health care costs is sensible and long overdue. The resulting increase in the awareness of non-institutional health care providers is likewise welcomed. However, there must be a simultaneous adaptation by both government and private payors of their coverage and payment policies to deal with both the long-standing limits on both acute and chronic home care and the increased need for these services due to the increasing life-span of the average American and the prospective payment drive to push people out of institutions earlier.

If government and private payors continue to constrict health care coverage and payment at both the institutional and non-institutional ends, two trends will emerge. One is that the gap in care will increase, putting more and more people in a limited or "no care" zone. Second, large numbers of people will seek, and obtain, re-admission to hospitals and enter nursing homes, which will defeat the cost containment goals of the government, private business and private insurers. Steps must be taken to insure that these trends do not occur, including assurance that any new, alternative reimbursement system for the Medicare home health benefit <u>is not</u> structured in such a way as to perpetuate or increase the "care gap."

IV. THE CHRONOLOGY OF THE ATTEMPTED DISMANTLING OF THE MEDICARE HOME HEALTH BENEFIT

IV. THE CHRONOLOGY OF THE ATTEMPTED DISMANTLING OF THE MEDICARE HOME HEALTH BENEFIT

Over the past few years, home health agencies have been faced with a barrage of administrative actions designed to restrict services and undercut the benefits promised to senior and disabled citizens under the Medicare law. Many of these actions have been implemented by circumventing the regulatory process.

Substantive changes, which should be published for comment in the Federal Register before implementation, have informally been implemented through "guidelines" published in HCFA manuals or by written or verbal "policy directives."

Policy revisions, which are published, are frequently published as "interim final regulations," again denying the opportunity for public comment. In addition, the Department has frequently failed to adhere to other procedural requirements, such as the required analysis of a proposed rule's impact on small businesses.

This conduct violates the Administrative Procedure Act, the Regulatory Flexibility Act, the Paperwork Reduction Act of 1980, and Executive Order 12291. It hinders cost-effective and rational administration of home health agencies and of the Medicare program. And, it is the enabling mechanism for DHHS' systematic assault on the benefits mandated by Congress under Medicare.

At the outset, it should be understood that the benefit is a highly limited one. The best way to understand this is to think of the Medicare statutory entitlement as a box.

In order to qualify, the beneficiary has to fit inside this box. The left side of the home care box is the requirement that a Medicare patient qualify for "skilled nursing care." In other words, the patient must be sick enough to need the intensive nursing and medical care, as distinguished from personal care alone. One element of skilled care, for example, is that a patient must have rehabilitative potential. This is the fundamental threshold which all patients must cross enroute to coverage.

The right side of the box is defined by the term "intermittent care." In other words, the patient must not be "too sick." He or she must need care intermittently, as opposed to on a full-time basis. Patients who need care more frequently than on an intermittent baisis, are thought too sick to be cared for at home and should be in a nursing home. This, of course, makes no sense as a matter of public policy. First, home health agencies are presently caring for individuals on a full-time basis when supported by non-Medicare payment sources. Second, nursing home care is not a viable option. Few people qualify for such care under Medicare. Third, if neither home care nor nursing home care are available, the ultimate effect is to leave individuals who are in need of health care to fend for themselves.

The bottom of the box is the term "homebound." In the regulations, this means that an individual qualifies for care if he/she needs the assistance of a walker, or a wheelchair, or the aid of another person to leave home. In practice, this requirement is being defined more and more restrictively to the point where it has come to mean "bedbound."

The top of the box relates to the fact that care must be ordered by a physician, and must be, in the judgment of Medicare officials, "reasonable and necessary" towards improving the patient's condition.

There were other limitations in the statute which were removed by the Congress in 1980. For example, prior to that time, for-profit agencies were not allowed to participate in Medicare unless states enacted specific laws allowing them to do so. Second, there was a limitation of 100 visits in any particular year. Third, in order to qualify for benefits, the patient first had to be hospitalized for 3 days.

In the place of these limitations, HHS has, over the last 2 years, added layer after layer of red tape, restricting the box and bringing the four sides closer and closer together until it resembles an Alfred Hitchcock elevator.

At the same time, HHS has compounded the problem by increasing the number of patients discharged into home care by 37%. The adoption of DRG reimbursement for hospitals has made this inevitable. While sicker patients are being discharged and the burden has grown, HHS has simultaneously reduced reimbursement to home health providers in a drastic way and now seeks to increase the portion of costs which must be paid out-of-pocket by beneficiaries.

HHS has justified its actions by producing a small-scale study from which it has never produced written case analyses for public review. Instead of using a large, more reliable random sample and a broader base study, HHS relies on this analysis of 39 home health agencies, which it asserts has produced results typical of all home health agencies participating in the Medicare program. The study in question suggests that some 30% of the patients receiving care under Medicare fell outside the home care box, i.e., they were either too sick, not sick enough, or not home-bound, or in the judgment of HHS officials, the care ordered by physicians and given by home health agencies was not reasonable and necessary.

The simple fact of the matter is that the box is growing smaller. HHS has pilloried home health agencies for not being within the lines and has used this as an excuse to draw the lines ever more tightly.

The real issue, of course, is money. In terms of percentages, home health care is the fastest growing part of Medicare. HHS seems intent on restricting this growth, arguing in justification that growth is fueled by proprietor greed and ignoring the fact that the growth was created by HHS itself through the implementation of the DRG reimbursement system. Saving millions of dollars by moving patients out of hospitals more quickly, HHS now seems to be trying to burn the candle at both ends, rather than accepting the modest increases in the level of home health expenditures which is the direct consequence of its own action.

HHS points to the fact that expenditures for home health care have increased from about $1 billion in 1980 to about $2 billion this year. It points to the growth in the number of certified home health agencies from some 2,000 in 1980 to 6,000 in 1986, and it points to the increase in average agency per-visit costs. HHS contends that these facts, taken together, are evidence that the home health benefit is out of control.

As for as the number of agencies is concerned, it is the Congress and HHS which have acted to increase their number. Analysis will show that the growth in the number of agencies falls primarily in two categories. First, proprietary agencies have increased dramatically because Congress in 1980 removed the prohibition against their participation in Medicare. Second, hospitals have more and more added their own home health agencies in order to insure continuity of care in reaction to the implementation of the DRG system.

Even though the number of agencies has increased, statistics from the Department of Health and Human Services continue to show that in excess of 5 million Americans are going without the home care that they need. In addition, there continues to be a need to create new home health agencies in rural and underserved areas. In fact, Congress has created a program which provides grants to create such agencies. Finally, the statistics used by HHS showing an increase in the number of agencies to 6,000 fail to reflect that agencies are increasingly turning away from Medicare. For the 6,000 agencies that do participate in Medicare, there may be as many as another 6,000 in the United States that do not choose to do so.

In terms of the increase in Medicare payments for home care from $1 billion in 1980 to about $2 billion in 1986, several points can be made. First, a 100% increase sounds large, but when one starts with such a small base, percentage increases really do not mean very much. Second, the increases by and large have resulted from the enactment of the DRG system and should be recognized as a reasonable offset to the billions of dollars saved in the Medicare hospital benefit. Third, a comparatively small percentage of the nation's 31 million Medicare beneficiaries actually benefit from home care. Last year, only about 1.2 million of the total had any utilization of the home care benefit. Fourth, home care still constitutes a tiny fraction of all Medicare expenditures, something like 3% of the total.

With respect to the increased cost to the individual agencies, it must be stated that this is logical because of the enactment of DRGS which have pushed into home care larger numbers of patients with intensive medical and nursing needs. Second, according to studies by the Department of Health and Human Services, the primary factor in the growth of agency costs is inflation. A 1984 study, for example, indicated the increase in costs shown by agencies fall into several categories as follows. 9.9 percent of the increases came from the fact that the number of individuals enrolled in Medicare had increased. Put another way, there has been approximately a 10% increase in the number of older Americans in the past 10 years. 47.5 percent of the increase resulted from the fact that more people used the Medicare home care benefit, although, as noted above, only 1.2 million of the 31 million Medicare beneficiaries actually used the service. Some 7.7% of total increased costs was the result of individuals receiving an increased number of visits. This, too, is predictable given the effect of DRGs. The remainder, or 34.9%, of the increase reflects as an increase in the average cost per visit.

A detailed analysis of the 34.9% shows that inflation accounted for 96% of all increases in the average cost per visit. Only 4% of the cost increase falls outside of that figure.

In short, HHS seems intent on reducing expenditures for home care in every way possible. HHS has placed obstacle after obstacle in the way of coverage. They have made it more difficult for beneficiaries to qualify for service. They have

made it more difficult for home health agencies to provide that service. They have made it more difficult for home health agencies to be reimbursed for services that they have given. They have made it more difficult for home health agencies to appeal the denials that they have received from intermediary insurance companies. They have blocked home health agencies from assisting Medicare beneficiaries in filing appeals when they have received denials in coverage from Medicare. HHS has also increased the pressure on intermediary insurance companies to audit and to find at least $5 in disallowed claims for every $1 that they spend on an auditor's salary.

The aggregate effect of all of these restrictions significantly undercuts the Medicare home care benefit. Following is a short summary of actions taken by HHS to restrict the home care benefit:

(1) REMOVAL OF WAIVER OF LIABILITY PROVISION

HCFA issued proposed regulations in the Federal Register on February 12, 1985, to eliminate, in effect, waiver of liability protection for HHAs, SNFs, and hospitals. Despite overwhelming levels of comment including that of HCFA policy personnel favoring continuation of the protection, HCFA issued its final regulation, February 21, 1986, eliminating presumption of favorable waiver status.

The waiver presumption was placed in the law to protect providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated. In these cases, the Medicare program does nothing more than make the provider whole.

In the home health setting, in order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of the Medicare services given. Any agency which exceeds this limit is not reimbursed irrespective of whether it accepted beneficiaries and acted in good faith. This requirement forces an agency to use due diligence in determining eligibility.

With home health agencies shifting to a system of ten new regional intermediaries, it is particularly important that the waiver presumption be preserved so that HHAs have some cushion for error as they adapt to the differing interpretations of the Medicare regulations and guidelines of their new FIs.

This proposal was advanced by the Administration for the last five years and was rejected by the Congress. Its implementation serves to further undermine both public and provider confidence in the Medicare program. It makes accepting Medicare patients a kind of "Russian Roulette" at a time when more rather than less certainty and predictability is required.

(2) APPLICATION OF THE "INTERMITTENT CARE" REQUIREMENT

In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24 hour-a-day care. The present guidelines allow for daily visits for a maximum of three weeks. Thereafter, visits may be continued upon a showing of exceptional circumstances. Moreover, the guidelines have permitted more than one visit to the same patient on the same day, perhaps one visit from a nurse and another from an aide depending on a showing of need. Information collected from a numer of States indicates that various restrictive

interpretations of the term "intermittent" are being imposed by some intermediaries. In some instances, it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances, clients who are in need of and who receive services 5 or even 3 days a week are being deemed as in need of daily care and therefore not compensable. There are even reports that such determinations based on restrictive interpretations are being applied retroactively resulting in retroactive denials.

The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy and other services into the hands of home care agencies who are being told that they cannot care for them because they need more than intermittent care. With the hospital prospective payment plan now in effect, the problem is likely to be exacerbated, with patients being released from hospitals more quickly and in sicker condition. The further irony is that government policy is pushing many clients into institutional settings when they prefer to stay at home with resulting increased costs to the government.

Definitions of what constitutes "intermittent care" vary tremendously, depending on the fiscal intermediary's interpretation. As a result, Medicare, which is supposed to be a national program, is not enforced uniformly and what is covered for one beneficiary in one state is not covered in another state.

(3) COST FINDING AND ALLOCATION ISSUES

The Medicare policy on direct or "discrete" cost-finding as part of the reimbursement methodology is causing problems for those home care agencies which also operate ancillary, non-Medicare home health businesses or non-home health programs such as preventive health programs. Medicare accounting policies are pushing costs into these programs which agencies cannot tolerate if they are to remain financially viable. This is occurring because home health agencies in preparing cost reports are not being permitted to identify those costs and programs clearly unassociated with delivering Medicare services and treat them separately or "discretely" for Medicare accounting purposes. These areas then would not absorb, through the cost allocation process of "step down," the spreading of administrative costs commonly incurred throughout the Medicare provider agency. Medicare personnel and FIs are retroactively imposing policy requirements concerning documentation and HHA business structure which have resulted in demands for large recoupments of prior payments.

Congress has stated that the cost of the Medicare program should be borne by Medicare and not passed along to other programs. The current statute and regulations do not prohibit home health agencies from using sophisticated methods of cost finding to identify costs more accurately prior to the step-down method of cost-allocation on the cost report. However, the Provider Reimbursement Manual (HCFA Pub. 15 - Sections 2308 & 2310) has prohibited use of sophisticated methods of cost finding by freestanding HHAs, even if submitted to and approved by the intermediary in advance. As a result, many agencies are forced to have an inaccurate portion of certain costs allocated under the step-down method, or to undertake corporate reorganization to separate non-Medicare costs out of the Medicare step-down methodology. HCFA's current published policy is inequitable, promotes inaccuracy and needlessly promotes corporate reorganization for reasons other than economic efficiency.

(4) SELECTIVE BILLING - BARRIERS TO COORDINATION OF BENEFITS

Fiscal intermediaries--with the approval of HCFA's Bureau of Eligibility, Reimbursement and Coverage -- are advising HHAs that if patients are receiving coverage under Medicare, in many cases they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Title XX, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week paid for by Medicare, and he or his family wants an additional 2 hours of nursing care on the other 2 days which will be paid by concerned relatives, Medicare intermediaries will deny the Medicare coverage. This either will result in no care, limited care, or the forced institutionalization of an individual whose family cannot sustain him at home if Medicare refuses to pay its fair share.

Medicare's logic for such denials is that if a person receives care beyond what Medicare will cover, then the person needs more than "intermittent care" and is ineligible for Medicare coverage. Thus, Medicare is seeking to both prescribe the need (i.e., the limits of intermittent care) and to be second payor. This approach limits the availability of services to beneficiaries and availability of payment sources to beneficiaries and HHAs. Furthermore, the Medicare intermediaries will deem this a "technical" denial depriving the HHA of a right of appeal.

There is no basis for the "selective billing" policy in law or regulations. It exceeds the authority granted to HCFA and its fiscal intermediaries. To allow such a policy to exist makes the Medicare benefit "means-tested," which clearly is not the intent of the existing law.

The current policy discriminates against home health agencies because it seeks to deny coordination of payment sources for benefits, while such coordination is permitted for hospitals and under the new Medicare hospice benefit. The law makes no such distinction between hospitals, hospices and home health agencies.

Further, the current policy is illogical. Where the patient receives his Medicare-covered care from one HHA and other covered care (paid from non-Medicare sources) from another HHA, both HHAs are paid and the patient receives his full coverage from all payment sources. It is illogical not to allow such coordination of benefits where the care is being rendered through one HHA.

(5) DISALLOWANCES OF APPROPRIATE ADMINISTRATIVE COSTS

HCFA has endorsed policies to create Medicare disallowances of reasonable and appropriate administrative costs associated with the business of patient care. Examples of areas of disallowance are (a) portions of dieticians' time spent doing in-field assessments but not billed as visits; (b) costs of educational conferences discussing improvements to managment of health services delivery; (c) costs of participating in local health planning agencies' certificate of need proceedings; (d) reasonable compensation screens and their application.

Congress intended Medicare beneficiaries to receive the highest level medical services based upon this need, delivered in an efficient manner. Reasonable administrative costs common in the industry and necessary to the proper running of a business dealing in patient care are reimbursable according to clear statutory language and Congressional intent. HCFA disallowances of the kind listed are not legally supportable, and HCFA should rescind any guidelines or directives to fiscal intermediaries which have endorsed such disallowances.

(6) HMO PARTICIPATION IN THE MEDICARE PROGRAM

HCFA published a proposed rule in the May 25, 1984 Federal Register (at page 22198) regarding participation in the Medicare program by Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). The final rule appeared in the January 10, 1985 Federal Register Volume 50 at page 1314. The rule allows HMOs and CMPs to receive a prepaid amount for serving Medicare clients, provided the HMO makes available all services and benefits required by Medicare. The regulation requires that when such an HMO contracts out provision of Medicare home health services, it must do so with a Medicare-certified HHA. However, if an HMO decides to provide the home health services internally, its home health component need not be separately certified under Medicare. As of January, 1986, no mechanism has been developed or published by HCFA or DHHS for ensuring that the HMO component home health services meet appropriate quality, frequency, administrative and other standards for Medicare beneficiaries. HCFA has stated in communications with NAHC that HMO-component home health services will have to meet the HHA conditions of participation, but no method for measuring and no responsible branch of government have been identified.

HCFA's failure to require an impartial demonstration as part of its HMO certification that an HMO meets the home health conditions of participation if the HMO provides home care from in-house raises serious quality of care issues, including the potential use of inappropriately trained and supervised independent contractors. It also puts Medicare-certified HHAs at a competitive disadvantage because they must incur the time and expense of meeting Medicare conditions of participation and applicable state HHA licensure and CON requirements. The quality of care issue becomes an even greater problem in states without HHA state licensure requirements because in such states Medicare HHA certification is the only control. NAHC believes the regulations should require any HMO providing home care from in-house sources to be reviewed and to show it meets the Medicare HHA conditions of participation as part of the HMO's certification process (not that the HMO's HHA would have to be a separately certified Medicare HHA). If the regulations are not so amended, corrective legislation, including state HMO licensure requirements of dealing with certified HHAs, should be pursued.

(7) PLAN OF TREATMENT AND DOCUMENTATION GUIDELINES FORMS 485-488

The home care industry endured a major HCFA administrative disaster in 1984 and early 1985 due to HCFA's attempt to force implementation of the poorly designed data elements forms 443 & 444. HCFA agreed to rescind forms 443-446 and to redesign the plan of treatment and medical information forms. This was undertaken in a 3-day workgroup session in March, 1985. HHAs were represented, as were certain of the fiscal intermediaries and HCFA regional office personnel. However, no major outside computer consultant group was brought to the workshop by HCFA or consulted in depth during the design period. The workgroup was presented with an outline of a form from which they had to work, rather than being asked for original design suggestions.

A parade of bureaucratic errors has ensued:

* The strongest recommendation of the workgroup -- that there be a field test of the design protocol -- was disregarded by HCFA.

* A rigid September 1, 1985 date for implementation was announced by former HCFA Administrator Carolyne Davis, and HCFA Bureau staff said no practical difficulties encountered would permit delay of that date.

* The other longstanding and frequently reiterated comment by NAHC that there be an extensive period for review and instruction on the guidelines for use of the forms was not heeded by HCFA staff.

* Instructions were not available until July, 1985.

* No hardcopy training and explanation guidelines were provided the FIs, who received oral training only.

* Supplies of the forms and instructions were very late in reaching the providers in the field.

* No schedule of training sessions by the FIs was demanded or even recorded by central HCFA staff.

* In most states, training sessions were given close to or even after the September 1 starting date for use of the form.

* Multiple areas of confusion and massive difficulties with the design, the physical quality of the forms and particularly the computer specifications, were identified by providers and FIs and communicated by NAHC to central HCFA. The response was that the industry would have to do the best it could, that costs of implementation were not being measured by HCFA and the industry would have to present whatever facts it could on administrative burden.

* HCFA's computer division in the Bureau of Program Operations continued insisting -- despite unanimous comments from HHAs, FIs and computer companies -- that there was no problem with the computer process for use and transmission of the forms.

NAHC's survey of the HHA cost and time impact demonstrates huge administrative burdens created both by the use of this form as designed and by the implementation fiasco. Early indications from the trial quarter of 1985 (the first 3 months of use) are that FIs are issuing massive denials without utilizing the form 488 or other methods of seeking medical documentation. Processing of claims by FIs has slowed to as much as 25% of the prior processing rate - 4 to 8 week turnaround times are reported by FIs. Despite assurances from central HCFA that FIs have been instructed to be "flexible" and "lenient," the contrary has occurred. Requests for accelerated advance payments are being denied. HHAs are expending huge amounts of time and money to deal with this documentation crisis -- while being paid at new lows under cost caps which did not include this kind of administrative expense.

While NAHC recognizes and supports the interest HCFA has in using universal forms which may be processed consistently and which could provide important data, bureaucratic errors and unrealistic adherence to timetables in this situation have caused extensive and unnecessary confusion and massive expense. Home health providers and beneficiaries should bear no part of these costs.

(8) DESIGN AND IMPLEMENTATION OF A SYSTEM OF TEN OR FEWER INTERMEDIARIES FOR HOME HEALTH AGENCIES

Pursuant to Section 2326(b) of the Omnibus Deficit Reduction Act of 1984 (P.L. 98-369 - signed into law July 18, 1984), HHS is taking action to alter the current 47 designated intermediaries system for Medicare home health agencies to a system of ten or fewer intermediaries (FIs) by no later than July 1, 1987. NAHC filed extensive written comments and met frequently with HCFA in 1985 concerning its planned new system, scheduled for implementation during fiscal year 1986. In the final notice, published February 13, 1986, HCFA responded to some but not all the issues. NAHC remains concerned about: the selection of very small organizations with little experience with HHAs to service large volume areas; the computer capability of the selected organizations; the ability of HHAs to choose an alternate FI without extensive HCFA resistence; and the failure of HCFA to consider serious conflicts of interest between certain FIs, which are major health service deliverers as well as insurance companies, and the HHA health service providers they will be monitoring.

NAHC continues to believe any system to implement the Section 2326(b) mandate should have been promulgated as a regulation pursuant to the Administrative Procedure Act (APA). HCFA's "proposed notice" with comment period and the extensive communications it has had on the issue was useful but did not permit an initial period of comment and proposal from the home care community prior to the initial tentative ten intermediaries selected by HCFA. No formal request for proposals (RFP) was issued by HCFA to the 47 FIs, some of which might have placed useful information on the record for comment.

HCFA must ensure a transition which is legally sound, operationally smooth and cost-effective, and which does not cause undue disruption to the cash flow and overall operation of HHAs and intermediaries.

(9) COVERAGE COMPLIANCE REVIEW GUIDELINES AND AUDITS

In December, 1984, HCFA changed the coverage compliance review requirements. Transmittal 328 revised Section 2300.1 - 2300.5 of the Medicare Intermediary Manual, Part 2 (HCFA Pub. 13-2). Among other changes, the revision mandated five home visits to beneficiaries (without notice to HHAs); reduced from 5 working days to a 24 hours in advance phone call the notice to an HHA that an on-site review would be conducted; deleted the random selection requirement for the 20 beneficiaries being reviewed and allowed "any in-house source deemed appropriate" to be used as a basis for selecting requirement for the 20 beneficiaries being reviewed; lengthened the time period within which 3 months of sequential billings/beneficiary should be selected from the most current 3 months to the most current six months; and added Medicare home health aide utilization as a fourth ranking criterion in the selection of HHAs for on-site review.

Valid and reliable statistical techniques should be used in on-site reviews where the results of the sample findings can affect an HHA's PIP, waiver and 100 percent review status. Reasonable advance notice is necessary as a matter of equity, and to ensure that proper staff and records are available. NAHC believes many of the revisions create an inequitable situation, are based on statistically invalid and unreliable sampling techniques, and deny the HHA adequate notice to prepare appropriate records and staff and to accompany review staff to beneficiary homes.

NAHC has begun to record numerous examples of coverage compliance audits under the new guidelines which have been conducted unfairly with massive, inappropriate denials. The on-site audits also have generated additional administrative burdens for the agencies because of agency staff overtime, agency-supplied transportation demanded for auditors and photocopying demands of Medicare auditors. Some form of informal appeal or review should be permitted of the often unreasonable denials and criticisms made by on-site reviewers.

(10) TECHNICAL DENIALS

HCFA policy makers have created a form of coverage denial called "technical denials" which are increasingly being imposed on HHAs. A technical denial of a visit is based on the FI's determination that the visit failed to meet a statutory or regulatory requirement other than medical necessity. By HCFA edict, technical denials are not subject to payment under waiver of liability and are appealable only by the beneficiary. Examples of "technical" denials are those where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requirements despite the fact that the home health agency has made a professional medical judgment that the patient has done so. Other "technical" denials may be based on the FI's determination that the patient received a non-skilled or other service not covered under the Medicare home health benefit. Recently, HCFA has directed FIs to treat as "technical denials" home health aide visits monitored as part of a skilled service which the FI denies but pays under waiver. This effectively abolishes any opportunity for the provider to appeal any aspect of the associated denials, and has resulted in extensive financial harm to many HHAs.

(11) INABILITY TO APPEAL CLAIMS PAID UNDER WAIVER

Under current HCFA guidelines (Section 256, HIM-11), an HHA has no right to appeal a claim denial if it is paid on waiver. HCFA asserts the HHA paid under waiver has no liability, is not at risk and therefore, should not have the right to appeal. This situation is exacerbated by the fact that particularly controversial denials often are paid under and charged to waiver immediately before the opportunity for the administrative review or reconsideration procedure. Often the claims paid under waiver are for services rendered many months before the FI processes the claims. The same services have continued to be rendered to those and other beneficiaries in intervening months and may be considered medically necessary by the provider and certifying physician on a current or future basis.
HHAs should be given the right to directly appeal FI decisions to pay by waiver instead of regular payment because there is no statutory or regulatory basis for the HCFA guideline. In addition, the logic is incorrect, because there is harm to HHAs. When claims are paid under waiver, they affect the HHAs' waiver level and can push them over the 2.5 percent threshold. This can result in the loss of waiver, affect eligibility for PIP and increase the administrative burden, all of which have significant impact on cash flow, particularly for small agencies. Third, absent statutory authority to the contrary, the HHA should have, as a matter of basic equity, the right to dispute an FI's decision on whether to pay a claim under normal payment or waiver.

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(12) INABILITY TO HAVE WAIVER STATUS RECORD ADMINISTRATIVELY ADJUSTED

FIs retroactively take HHAs off waiver where the FIs made errors in honoring claims which should have been disallowed. However, FIs will not enter in the HHA's records the fact that waiver status was erroneously denied because the FI (or an Administrative Law Judge) has reversed the claim denials which caused the loss of waiver. In one of many examples, a Chicago-based HHA lost its waiver because of 85 visit denials in one quarter. After going to hearings, a total of 87 percent of the denials were reversed. If there had been a retroactive adjustment to the affected quarter, the denial rate would have dropped from 4.66 percent to 1.86 percent. The HHA received reimbursement for the reversed denials, but there was no entry in the HHA's records that the waiver status was erroneously lost for the affected quarters.

Sequential loss of waiver can result in adverse effects on PIP qualification.

Where subsequent appellate actions find the initial loss of waiver or the rate was wrong, an administrative restoration of the HHA's waiver status or rate should be put in writing in the HHA's record (and all other applicable records) so as not to jeopardize the HHA. Such a correction of records is a matter of equity and proper administration of the Medicare program. The number of times an agency loses waiver and/or the rate at which it exceeds the 2.5 percent level is used to determine an HHA's eligibility for or continuation on PIP, whether it will be selected for a coverage compliance review and whether it will be selected for review by the Office of Health Financing Integrity or other HCFA reviewers.

(13) FAILURE TO PAY CLAIMS WHEN HHA IS UNDER WAIVER

If an FI reviews an HHA's claims and finds that the HHA is within the 2.5% error rate, the claims subsequently reviewed and denied are payable while the HHA is under waiver unless the FI has evidence the provider knew or had reason to know that a particular claim was not covered under Medicare. (This is the essence of the favorable waiver status.) The FI which believes the provider should not have particular claims paid because of "knowledge" has an obligation under the regulations to show how the provider "knew" the particular services for that particular patient were not medically reasonable and necessary. However, HCFA recently has stated that an FI is correct in sending an HHA on waiver a blanket denial letter without providing identification of the specifics which preclude payment under waiver. HCFA acknowledges the FI must have justification "in the files" but sees no reason to have the information communicated with the initial denial letter.

An HHA under waiver as a result of favorable demonstration of ability to make coverage decisions has both a right under the regulation to be paid for inadvertent (but statistically infrequent) errors on coverage decisions and a right to be informed sufficiently by the FI of "knowing" errors so that the HHA can attempt to preserve its accuracy in coverage determinations. HCFA cannot defeat presumptive regulatory rights, and should not place the obligation on providers to investigate the FIs files without a specific rebuttal on specific facts demonstrating an HHA "knew" of non-coverage either by prior, unreversed denials of particular services of the same kind, or by a manual or other communication concerning specific services which were deemed noncovered in all instances.

(14) HCFA's FAILURE TO USE STANDARD STATISTICAL STANDARDS OF VALIDITY AND RELIABILITY IN PERMISSIBLE SAMPLING METHODOLOGIES

HCFA does not use generally accepted statistical standards of validity and reliability in most home care programs where it uses sampling. These include the sampling used in fiscal audits; in the post-payment review process; in the on-site coverage compliance reviews; in the conduct of various research projects examining home health policies and procedures; and in the fiscal intermediary evaluation program (CPEP). Changes in the method for determining waiver of liability status have some, but not all, of the necessary components of acceptable statistical sampling. As a result, the findings of these programs cannot statistically be relied upon to reflect the actual operations of HHAs and intermediaries. Nevertheless, these invalid or partially valid and unreliable methodologies are used as a basis to deny claims, project overpayments, decide an agency's waiver and/or PIP status, and decide if a HHA is eligible for PIP or should be subject to 100% review.

Generally accepted statistical standards are necessary to give an accurate measure of the behavior of HHAs and intermediaries in order to develop appropriate corrective measures. Invalid and unreliable sampling techniques will result in actions which are inappropriate and may be unnecessarily punitive to HHAs.

(15) BONDING AND ESCROW REQUIREMENTS

On November 25, 1985 HCFA issued a notice of proposed rulemaking in Volume 50 of the Federal Register at page 48435, which would require financial security arrangements for HHAs in the following circumstance:

1. HHAs in existence less than three years, as evidenced by having less than three settled cost reports, would be required to have a bond or escrow account in an amount of 10% of estimated Medicare costs for their first year.

2. HHAs with year end, cost report overpayment recoupment demands from FIs of 15% or greater of the HHA's Medicare costs in any of the last three years would be required to post security for an amount equal to the largest overpayment in that period.

3. HHAs with 85 percent or higher Medicare utilization (measured by visits) would be required to post bond or obtain an escrow account unless they could demonstrate they had not had a significant overpayment or had repaid any without borrowing.

Although NAHC is firmly behind reasonable efforts to safeguard the Medicare Trust Fund, and to forestall any occasion in which home health agencies (HHAs) intentionally operate to jeopardize the financial security of the home care system, the proposed regulations are:

(a) Insufficiently Supported in Fact; both in the background materials supplied in the proposed regulation and in the historical record in recent years, to support so stringent a requirement. By HCFA's own admission, only 9 percent of HHAs report significant overpayment in a year, and the number of HHAs that actually default is a

much smaller number than that. However, the regulation would require approximately 4500 HHAs to be bonded during the initial three years of their status as "newly established" HHAs or by virtue of their high Medicare utilization.

A miniscule number of home health agencies (32 in the 1965-1980 period) proportionate to the more than 5875 now certified have actually fully defaulted on Medicare debts. Existing Medicare repayment procedures ensure both return of monies and interest to the Medicare Trust Fund; flexibility in granting longer term repayment schedules permit agencies to remain viable and deliver necessary services to beneficiaries without disruptions in care. No current rising tide of defaulting HHAs exists. In stark contrast, NAHC is aware of thousands of HHAs experiencing extensive delays in the processing of their claims by Medicare FIs. (Hundreds are considering or have already secured loans to cover immediate costs of payrolls.)

* The proposed regulation requirement that each subunit of a HHA must establish its own financial security arrangements ignores the financial viability that a parent organization may be able to demonstrate over time. Absent a justification and demonstration of the HCFA factual basis for this requirement, NAHC finds it unsupported.

(b) Overly Broad and Restrictive. If any financial security arrangements were imposed, they should be prospective only in their application.

* "New" home health agencies receiving initial Medicare certification after the implementation of such a regulation should be subject to the requirements for no more than one year as evidenced by one finalized cost report.

* HHAs with "significant" overpayments. Factual inquiry is necessary to identify the causative elements outside the activity of an individual HHA which may contribute to a HHA's development of significant overpayment problems. These elements include: (1) whether the fiscal intermediary has been attentive and effective as a monitor of newly established HHAs by properly instructing and reviewing accounts from these agencies; (2) whether the existence or presumption of waiver status for newly established HHAs ought instead to be delayed until after an initial period of demonstrated competence; (3) what the history has been of the FIs providing accurate coverage determinations (including the FIs' rate of reversal on reconsideration or administrative law judge proceedings), (4) and finally to what degree central HCFA policy guidelines have been vague or non-existent in serious areas of concern such as "discrete costing" of non-Medicare costs on the provider cost report and related documentation requirements communicated unclearly to the provider community. Many major overpayment disputes involving HHAs have flowed from clear failures to communicate programmatic requirements, retroactive shifts in program policy, and announcements of program requirements which do not match industry practice over time.

(c) Unjustified if Applied Because of Medicare Utilization Equal to or Greater than 85 percent of Visits.

* Although the initial Congressional concern may have, in part, focused upon providers which are heavily Medicare-dependent, in fact the development and utilization of the Medicare home care benefit has been endorsed by Congress, and its delivery made possible by home care providers willing to accept the less than full reimbursement rates available under Medicare as a result of the cost limits schedules.

* The proposed restrictions would virtually eliminate the agencies which are small, privately owned, those county or state-based and others particularly devoted to community care. This sort of HHA has remained devoted to servicing the Medicare beneficiary, has no "deep pocket" resources to fund an escrow account and may be legally barred from doing so, if government-based.

* This portion of the proposed regulation is a first step toward rationing care without appropriate Congressional action for such an undertaking. Congess would not support a narrowing of the home health benefit, and this regulation attempts to do so indirectly.

* The proposed methods by which a high Medicare-utilizing HHA could exempt itself are so vague as to be a virtual guarantee of inconsistent and, therefore, unfair application nationwide.

(d) Not Feasible to Implement Due to Lack of Available Financing Sources.

* HCFA has presented no evidence suggesting that it has researched the availability of bonding and the availability of income sources for escrow accounts for the home health providers it proposes to cover by the proposed Rule. NAHC has found, as did its predecessor organization, the National Association of Home Health Agencies (NAHHA) which surveyed HHAs in 1981, that bonding simply is not available to home health providers in current financial markets. The cost figures HCFA reports in its proposed regulation of $20 per $1,000 certainly are no longer available for any provider market.

* HHAs cannot find willing lenders in current times, since HHAs are facing: (1) major cash flow problems associated with the new HCFA Forms 485-488, which have had such a difficult implementation period; (2) rising number of denials and documentation requests issued by fiscal intermediaries; and (3) the necessity to seek short-term loans to meet these cash flow problems associated with HCFA administrative changes. All have rendered the possibility of raising significant funds to place in an escrow account highly improbable.

The enormous number of regulatory changes and restrictions imposed on HHAs in 1985 have continuing impact in 1986 and, including UB-82, the new cost limits methodology and the new FI system, make it less likely now than in 1981 that agencies - especially small rural agencies -- would be able to obtain a bond or capital for an escrow account.

(e) Restrictive of Agencies' Rights in Seeking an Appeal of Medicare Disagreements.

The imposition of major financial requirements, such as the creation of an escrow account, for HHAs which have entered into a repayment arrangement but which are planning to contest the underlying issues which have led to their overpayment status, especially unusual, or significant policy determinations by Medicare policy personnel -- such as the utilization of retroactive "discrete costing" requirements or the utilization of statistical sampling projections -- places HHAs in a position in which their appeal rights may be abridged if they are forced to divert limited financial resources to an escrow account, rather than to support of their appeal.

(f) Administratively Expensive and Inequitable.

* The requirements, as outlined, will be extremely expensive for the FIs to administer and extremely expensive for HHAs at a time of rising administrative costs associated with new documentation requirements. The added non-reimbursable expenses will be another expensive demand on certified HHAs, reducing or eliminating their ability to bid competitively for contracts with health care systems such as HMOs.

* The regulation requires skills and judgment from FIs in areas involving financial assessments, long-range financial viability and management potential of businesses, legality of arrangements of indebtedness, and other related factors for which FI employees are not educated or prepared.

* The vague, and in some cases legally questionable, discussion of "guarantee agreements" in the proposed rule suggests HCFA has not analyzed how such arrangements might affect not-for-profit organizations and their tax status or the ability of certain corporate organizations to serve as guarantors of their subsidiaries.

Without documented and demonstrable need for such additional, costly financial burdens on home health agencies, the proposed regulation is unjustified and detrimental to the Medicare beneficiary and home health agencies.

(16) ABRIDGEMENT OF APPEAL RIGHTS OF PROVIDERS AND BENEFICIARIES

There are numerous situations in which the Department of Health and Human Services and its agents have acted to obliterate, discourage or skew the existing appeal process available under Medicare statutory provisions and regulations.

1. Projections of Part A Claims Denials and Reversal of Claims

Fiscal intermediaries under HCFA direction have reviewed individual beneficiary Part A cases in several home health agencies and, finding alleged coverage questions in a small percentage of sampled cases, have projected those denials over all the visits and claims of a home health agency throughout its cost year. This means unknown beneficiaries' care and unknown coverage "errors" cannot be appealed on their facts by Medicare beneficiaries or the providers. Appeal rights for Part A Medicare claims of beneficiaries and providers which Congress has established by law, 42 U.S.C. Section 1395 ff, are obliterated. (See Section VI(1))

2. Interference with Appeal Process

HCFA has attempted to interject itself in various appeal procedures where, by the Department's own regulations, there is no HCFA role: (a) in administrative law judge (ALJ) proceedings for review of claims denials, (b) in petitions to the Appeals Council asking it to reverse ALJ opinions favoring providers and beneficiaries. The Appeals Council, by regulation, is an independent entity that reviews ALJ decisions on its own motion or by request of providers or beneficiaries only.

3. Discouraging Exercise of Appeal Rights

(A) Questions are being sent to Medicare beneficiaries who request reconsideration of Medicare claims denials -- the very first level of appeal. The HCFA-designed questionnaire asks verification of signature, asks for the content of any communication about the appeal between the beneficiary and the home health agency which had served him/her, and ends with the disquieting inquiry "Do you still wish to have reconsideration of this claim?" This communication is directed to an elderly, captive population of beneficiaries who frequently can be easily alarmed, intimidated or discouraged from asserting their rights in an aggressive fashion. There is an obvious breach of privacy attendant to the questioning. Beneficiary groups with which NHAS has communicated, such as the National Senior Citizens Law Center, are outraged. No regulation makes the sending or responding to such an inquiry part of the appeals process. No authorization to use such a questionnaire was obtained from the Office of Management and Budget under paperwork requirements.

(B) Certain administrative law judges from the Department's Office of Hearings and Appeals phoned beneficiaries and their families telling them that pursuing their appeal rights through a hearing was not in their best interests. No Departmental directive was issued nationally to warn that an ALJ acting in such a fashion abridges legal rights.

4. Forbidding Appeal

The coverage denial determination for claims paid under waiver is not subject to appellate review according to HCFA. (See (1) above).

5. Forbidding Provider Appeals of "Technical Denials" (See (3) above)

6. Forbidding Beneficiaries to Name HHA as Representatives in the Appeal Process
(See 22 below)

HCFA has been acting without legal authority in each of these areas affecting appeal rights.

(17) INTERMEDIATE SANCTIONS FOR HOME HEALTH AGENCIES PRIOR TO TERMINATION FROM MEDICARE PROGRAM

Pursuant to HCFA Manual instructions (HIM-11, section 142.2), HCFA may terminate a participating provider agreement with an HHA if it is determined, among other situations, that the HHA "is not complying substantially with the provisions of the agreement" or with applicable provisions of the Medicare statute or regulations, or if the HHA "no longer meets the appropriate conditions of participation." The termination is effective 15 days after notification to the agency, and the manual provides no reconsideration prior to available appeal procedures, under Medicare regulations 42 CFR section 405, subpart D. Because of numerous stringent interpretations and variations of interpretation under state surveying practices or federal validation reviews, an HHA may be alleged to have gone out of compliance with one or more of the Medicare conditions of participation but pose no immediate, actual and documentable risk or threat to the health or safety of any patient. Nonetheless, the Medicare program personnel currently interpret the Medicare regulation's requirement that an HHA be in compliance with the conditions as an absolute, permitting no interim period of agency functioning during the administrative appeal process.

Medicare certification of an HHA functions as the practical equivalent of licensure, and for a reputable HHA to be abruptly deprived of certification without an opportunity to work toward correcting alleged deficiencies, disrupts patient care and unfairly damages agency viability. Court opinions permitting termination of Medicare program participation prior to a formal hearing have focused upon the acute care, in-patient setting, such as nursing homes, in which full responsibility and control over every aspect of a patient's life lies with that institution. Only in a rare circumstance is an HHA likely to pose a comparable immediate threat of harm to a patient's safety and well-being.

(18) APPLICATION OF THE "HOMEBOUND" REQUIREMENT

A 1979 GAO Report recommended that the homebound requirement for home care be deleted. In 1981, a GAO Report criticized the homebound guideline (Section 208.4 of HCM-11) as being unclear and vague, causing inconsistent interpretations in coverage decisions.

In July, 1982 HCFA circulated internally a proposed new guideline that would have changed the Section 208.4 (HCM-11) guideline defining "homebound."

The new guideline would have reversed the existing presumption that a person need not be totally dependent and bedridden to be considered homebound. It would have done so by deleting the current guideline wording that to be homebound "the condition of these patients should be such that there exists a normal inability to leave home and consequently, leaving their home would be a considerable and taxing effort." The current guideline allows the patient to be considered homebound

if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional non-medical purposes" (e.g., trip to barber, a drive, walk around the block). NAHC believes this is a reasonable approach which balances the ability to have limited activity while being essentially confined to one's home and eligible for Medicare home health benefits.

(19) APPLICATION OF THE "SKILLED NURSING" REQUIREMENT

Every Congress going back to the 92nd Congress has gone on record in favor of an adjustment in the priority of government funding which has favored placing Medicare and Medicaid patients in institutions. Despite the progress that has been made towards encouragement of home care, the primary impediment to the delivery of home health services is a restrictive interpretation of "skilled nursing."

Some FIs say "skilled nursing" means "hands-on" care only and are denying any evaluation or assessment visits where the evaluation visit is followed by care. Some FIs are saying if more than one visit a day is needed, then the care is not skilled care because institutional care is needed. And some are assuming that if a family member/relative/friend exists, he can be taught regardless of any assessment of the nature of the procedure and the person's abilities. Other FIs are defining specific activities, which HHAs believe require trained nurses, as those which either a home health aide, relative, or family member could do. And other FIs are defining persons as "chronically unstable" and therefore not eligible for skilled nursing care because more than "intermittent skilled nursing care" is needed. In some states, the Medicare interpretation of skilled nursing activity contradicts the State Nurse Practice Acts.

(20) USE OF "VISITS" AS BASIS FOR BILLING HOME HEALTH AIDE SERVICES

HHAs currently are required to use a "visit" basis when filing for home health aide services in the cost report since the cost caps are based on visits.

Prior to this requirement, HHAs could use an hourly basis. The current requirement helps some HHAs and harms others. For the ones it harms, one reason is that some Medicaid and other State programs, and private insurers require an hourly basis for home health aide visits. The result is that (a) there is additional accounting time and paperwork, (b) there is a loss of funds where aides are paid on an hourly basis and the number of hours per visit exceeds the visit cap, and (c) the method can cost the Medicare program more money than is equitable. Furthermore, when the requirements of a homemaker-home health aide are properly divided between hours in the morning and hours in the afternoon or evening (transferring a patient from bed to chair, for example), some FIs consider the split time as two visits and disallow one. This problem has increased with the data entries on HCFA Forms 485-488.

HHAs should be reimbursed for their reasonable costs since the Medicare home health benefit is reimbursed on a cost-based system. The inability to allow for conversion of hourly costs into visit cost runs counter to the cost-based system and financially penalizes HHAs.

(21) LACK OF ADEQUATE STANDARDS FOR FISCAL INTERMEDIARIES

The current law, regulations and guidelines do not contain specific, binding timeframes within which fiscal intermediaries must process claims, respond to HHA or beneficiary inquiries, or process reconsiderations. Ranges of time periods

for responses by FIs are counted in their year end contractor evaluations (CPEP), but these are utilized for review purposes by HCFA and are not mandates for action. Thus, FI delay in meeting a reasonable time standard for payment of an HHA claim does not result in automatic payment issuing to the HHA. On the other hand, HHAs are held to specific time limits in terms of claims submissions, provision of supplemental claim data and filing of reconsideration requests.

Timeliness standards are essential for the efficient and effective operation of HHAs, including maintenance of an adequate cash flow and having notice as soon as possible on coverage policies as manifested in claims denial decisions. The latter is necessary to properly advise HHA staff of new or revised interpretations so they can appropriately adjust the nature and frequency of visits.

NAHC has called on HCFA, in NAHC comments on the move to a 10 Regional FI system, to require specificity in denial notices. This is crucial to achieving Congress's goal of greater consistency and cost effectiveness in a 10 FI system. NAHC will make this issue a central one in meetings with HCFA on the transition to 10 FIs. If HCFA does not achieve these goals through administrative directive, the regulation should be changed to:

(A) Require that either the denial notice and/or appropriate accompanying papers from the FI must specify each visit denied and the specific reason for each visit denial;

(B) Require that denial notices be sent to HHAs and patients in a timely manner, and in understandable language; and

(C) Require that HHAs get notification of denials prior to or, at a minimum, simultaneous with notification to patients.

The intent of 42 CFR section 405.702 was to give the HHAs and beneficiaries a specific basis for requesting a review or appeal and initiating corrective action in staff policies/procedures where necessary. The lack of specificity subverts the intent of the regulation and the rights of the appellate process.

(22) ABILITY OF BENEFICIARIES TO DESIGNATE HHA EMPLOYEES AS REPRESENTATIVES IN THE CLAIMS APPEAL PROCESS

In January, 1984, HCFA issued a revision to HIM-11 (Transmittal 150 changing Sections 257-A of HIM-11) which prohibits Medicare beneficiaries from designating HHA employees to represent them in the claims denial appeal process. Similar revision to Manuals were issued dealing with SNF and hospital employees. The rationale was that such representation per se represents a conflict of interest.

The Section 257A issuance is in violation of the law and should be corrected to restore full and appropriate rights to both beneficiaries and HHAs. It is also unconstitutional in terms of its lack of promulgation through the Federal Administrative Procedure Act process, and in terms of the existing regulation allowing beneficiaries to designate representatives.

(23) LACK OF CLEAR STANDARDS IN THE PERIODIC INTERIM PAYMENT PROGRAM

An even cash flow is vital to the survival of home health agencies. In recognition of this fact, HCFA has allowed agencies with good performance records to receive payments in advance which are computed on the basis of past billings.

The current regulations governing initial and continuing eligibility for the Periodic Interim Payment (PIP) program set only general criteria (42 CFR section 405.454). This results in individual intermediaries developing and implementing their own and varying specific criteria relating to such issues as: relationship of waiver status to PIP eligibility, criteria for evaluating requests for increases in PIP payment levels, timeliness of claims submission criteria, and handling of overpayment and underpayment adjustments to PIP, among other issues.

In many circumstances, the criteria were not even disseminated in writing with FI justification for the particular restrictions or requirements in keeping with the regulation. In the second half of 1985, some fiscal intermediaries refused to process requests to go on or adjust PIP, claiming they need not process requests while the fiscal intermediary system was being revamped and centralized to 10 regional intermediaries. New rules announced by HCFA would restrict the availability of PIP only to those agencies which have electronic (computer) billing capability. Most home health agencies do not have this capability and most of the intermediaries that will be processing their claims do not have adequate ability as of yet to process such claims electronically.

Further, on January 10th, NAHC received from HCFA a copy of Transmittal 1254, amending Section 3603 of the Intermediary Manual, HIM 13-3, to set out "timeliness" criteria for providers billing submission related to PIP eligibility. Dated December, 1985 with a January 1, 1986 effective date, the "30 days from date of service" language, linked to a requirement that bills pass FI edits, completely disregards the Form 485 crisis.

There should be a set of specific standard criteria which are equitable, reflect the intent of PIP, and are applicable to all intermediaries. NAHC and other concerned parties should be permitted to have input in the creation of any manual guidelines to the interpretation of the PIP regulation. The January, 1986 manual revision violates these notions of equity and fair process.

(24) INCREASING, EXCESSIVE, INCONSISTENT DENIALS OF COVERAGE

Home health agencies throughout the country have experienced new forms and alarming increases of denials of coverage for home visits. Fiscal intermediaries are issuing blanket denials of what is clearly skilled and medically necessary care of the type and intensity for which coverage was approved in prior years by the same intermediaries reviewing equally detailed cases. Fiscal intermediaries are also issuing partial denials, reducing approved payments from 3 to 2 visits per week, for example, despite physician orders for the greater number of visits and demonstrated need in the given case. Such partial and complete denials have not been preceded by any communication from HCFA or the FIs as to medical, scientific or regulatory bases for changes in coverage policy. Furthermore, FIs in different states are handling similar coverage situations differently, continuing the national pattern of inconsistent policy application.

Fiscal intermediaries are responding to HCFA's pressures to lower the total dollar amount of Medicare home health services approved, despite Medicare beneficiaries' entitlement under the statute to the full range of medically necessary home care. To satisfy immediate HCFA demands for "savings," FIs are issuing arbitrary and erroneous coverage decisions which then must be appealed -- an unnecessary increase of the long-term administrative costs of Medicare.

It is unfair to beneficiaries and home care providers, and administratively unsound, to develop and apply HCFA coverage policy in an intangible, retroactively announced fashion. It is unfair for HCFA to expect fiscal intermediaries to return $5 in "savings" for every $1 in administrative "costs" to the Medicare program with a rapidly growing Medicare population now receiving health services at home. Fiscal intermediaries should be provided with clear, consistent written instructions on the range of treatments and diagnostic conditions for which HCFA develops coverage policies of limitation of payment. These HCFA policies should be developed in keeping with statutes and regulations after open, detailed discussions with clinicians and administrative personnel from the home care setting.

CONCLUSION

These actions by the Department of Health and Human Services reflect the administration of policy in an arbitrary and capricious manner. The net effect is to subvert the intent of Congress in establishing the home health benefit under Medicare and restrict service unfairly at a time of explosive need.

For the beneficiary, our seniors and disabled, it all too often means being forced out of the hospital by the incentives of the prospective payment system for hospitals and denied the necessary continuing support services in the community.

By analogy, the Department is widening the care gap between the hospital and the community with one set of policies and blowing up the bridge with the other.

V. RESULTS OF THE SURVEY TO ALL HOME HEALTH AGENCIES IN THE UNITED STATES: MORE RED TAPE LESS MEDICARE COVERAGE

V. RESULTS OF THE SURVEY TO ALL HOME HEALTH AGENCIES IN THE UNITED STATES: MORE RED TAPE LESS MEDICARE COVERAGE

There has been a great deal of anecdotal evidence to support the premises that (a) millions of older Americans are going without the home care that they need; (b) the problem has been exacerbated by the enactment of prospective payment (DRG) reimbursement for hospitals participating in Medicare; and, (c) rather than recognizing the fact that the increased costs in the Medicare home health care benefit are a result of (a) and (b), the Department of Health and Human Services has paradoxically sought to reduce payments to home health agencies.

Several preliminary studies have been undertaken which seem to support this premise. The Senate Aging Committee, for example, reflects data from the General Accounting Office showing that patients are being discharged "quicker and sicker" and that there has been a 37 percent increase in the number of patients sent to home care since the DRG system went into effect.

Individual home health agencies have written both to NAHC and to Congress to alert them to the problems they are encountering first, in coping with the increasing number of individuals they have received who are in need of more intensive medical and nursing intervention and second, with the restrictions in payment which make reimbursement for services rendered less and less likely.

In order to flesh out this anecdotal information and be more responsive, the National Association for Home Care conducted a broad study of all home health agencies in the nation. Some 5,300 home health agencies were sent questionnaires. Some 2,100 agencies responded (an excellent 40 percent rate of return). Since the study was sent to the whole nation, and such a large percentage of participants chose to respond, the study must be viewed as statistically valid in every sense of the word.

In addition to the questionnaire, NAHC staff conducted follow-up inquiries with over 600 home health agencies (roughly 15 percent of all agencies in the U.S. and over 25 percent of those who replied in written form to the inquiry).

This study was the most comprehensive national study of its kind ever undertaken. The data from the study proves conclusively that:

1. Millions of older Americans are going without the home care that they need.

2. This problem has been exacerbated by the enactment of DRGs.

3. Demographics and new technology are also significant factors in increasing the demand for home care.

4. Patients are being received in record numbers by home health agencies. They are being discharged quicker and sicker. They need more intensive medical and nursing services and by and large require more visits to stabilize their condition. Such patients are invariably more expensive to care for and their growing numbers mean higher costs to individual agencies and to the Medicare program generally.

5. Rather than increase its funding by a few million of the billions it has saved by reducing inpatient hospital stays, the Department of Health and

Human Services has instituted a series of repressive measures which have resulted in (a) increased paperwork and red tape; (b) a tremendous increase in denials of reimbursement for patients cared for by agencies; (c) slowing down reimbursement until many agencies are without cash flow and in danger of bankruptcy; (d) eliminating the ability of many public agencies to serve indigents; and, (e) requiring the elderly or their families or other programs to bear a disproportionate share of what are properly costs reimbursable by the Medicare program.

Following are some of the major findings of this in-depth study:

* Fully 97 percent of the responding agencies reported that they had seen a significant increase in the amount of paperwork burden in order to respond to demands for increased documentation by the Department of Health and Human Services' Health Care Financing Administration (HCFA).

* Some 92 percent of the agencies reported they are seeing a sharp increase in the numbers of sicker patients requiring intensive medical or nursing care as a result of DRG reimbursement to hospitals.

* Seventy-five percent of the agencies responded that significant numbers of Americans in their community were going without the home care services they needed. This same percentage believes that the numbers of Americans going without care is increasing.

* Fully two-thirds (67 percent) of all home health agencies responded that they had seen a significant increase in the number of claims denied by Medicare over the past year. Respondents were asked to spell out in a little more detail the reasons given when Medicare rejected payment on the claims they presented which represented services they had given to elderly clients.

* Some 63 percent of those responding said they had seen an increase in denials with the excuse being that the patient's condition was not considered serious enough to merit "skilled nursing care." Most of the respondents felt such denials were unfair.

  Many offered comments or examples of patients who in their view required the most sophisticated nursing care imaginable. They could not understand how such claims could be rejected on the grounds that the clients did not need "skilled care." The consequence of this and all other denials is that the agency will not be paid even though they have rendered services in good faith to Medicare eligible clients.

* About 49 percent said they had seen a sharp increase in the number of so called "technical denials." HCFA has invented the term "technical denial" and is using it against the protests of senior citizens and consumer organizations, including NAHC. HCFA and their contractors use such denials for claims which mark situations where, in their view, the agency should have known that the patient would not qualify for reimbursement.

* Forty (40) percent indicated they had experienced an increase in denials with the excuse that the patients they had served were too sick to qualify for the Medicare "intermittent care" test. Under the Medicare statute, home health benefits may only be paid for if they are intermittent in nature. The rationale is that if a patient needs 24-hour care for a protracted period of time, he or she should be in a nursing home or hospital and is not a proper candidate for home care, at least under current law. Some of the sharpest letters of protest came with respect to cases of this nature, where the agency had extended service to someone obviously needy, only to have the claim rejected retroactively by some clerk in an insurance company office who had only the patient's chart to review and, using this, made the decision that reimbursement should be denied because the agency should have known the patient was too sick to be cared for at home.

* Similarly, 39 percent of the agencies responding said that they had seen a sharp increase in claims which were denied because the patient they served was not thought to be homebound. Once again the Medicare law limits home care reimbursement to patients who are homebound. In the past this term has been given reasonable interpretation. Indeed the existing regulations defining this point seem reasonable. Unfortunately, HCFA through their contracting insurance companies, seems to be defining this term more and more as synonymous with "bedbound" according to those who responded to the survey.

* Some 61 percent of the agencies reported, in addition to a sharp increase in red tape and increased paperwork burdens and the ever increasing number of claims denied, they were also experiencing a significant slowdown in Medicare payments over the past year. This fact has serious implications for home health agencies all across the nation. Typically, home health agencies are labor intensive and depend on Medicare for the majority of their income. Any delay in payment can quickly cause cash flow problems, forcing the agency either to borrow to meet payroll, to go into debt or into bankruptcy.

* When asked if the new proposed cost limits together with the new method for computing the Medicare home health cost caps would significantly reduce payments to their agency over the next year, fully two-thirds of the agencies responded in the affirmative. Asked for an estimate of what the loss would be, agencies offered a broad range from $10,000 to $7 million a year which they would lose. Most of those who replied said they assume losses will be about 10-15 percent of total revenues.

* More than half of the agencies responding reported their response to all of the above was to reduce their dependence on Medicare. This means that they will choose to serve fewer Medicare patients, to be more selective of which to serve, or to raise revenues through care of individuals who pay privately in order to subsidize the care of Medicare clients.

* While several agencies have reported publicly that they will leave Medicare, only 7 percent of all agencies responding reported they were going to leave the program. When probed further, most of the respondents noted their commitment to the aged and infirm as the reason they were working in the field of home health care and that whatever the obstacles, they would remain in it to care for those who otherwise would be in an institution or in a grave.

In order to document further these conclusions, a number of case histories are presented here. They describe typical cases of individuals who were qualified for Medicare and who needed service. In every case, a home health agency offered the care they thought was appropriate under the circumstances--care that was ordered by a physician, only to be told retroactively that such care should not have been given. The agencies were told in every case that they would not be paid for these cases, which were denied for various reasons. The cases are grouped below according to the reasons why they were denied for payment. It should be noted that when a case is denied, the agency has the choice of absorbing the loss or billing the patient and/or his family. Usually, the agency chooses to absorb the loss.

CLAIMS DENIED BECAUSE CLIENT ALLEGEDLY DID NOT QUALIFY FOR "SKILLED NURSING CARE"

* Mrs. A was an elderly woman who lived alone. She had a diagnosis of malignant sarcoma of the left hip. The sarcoma was ulcerated and draining, with a lesion approximately 4" deep and 5" in diameter. The home health agency provided daily dressing changes; sterile technique with medication and packing were necessary per the physician's order. Under state law, aides could not administer medications, and Mr. A was unable to perform the service herself because of severe arthritis and because the pain associated with the sarcoma prohibited her from bending or twisting. The fiscal intermediary denied the visits as not meeting the skilled nursing requirement. When asked for a reconsideration, the FI responded that the agency should have taught Mrs. A's neighbors to make the dressing changes.

* Mr. X is a 78-year old man suffering from wet gangrene of the right foot necessitating a transmetatarsal amputation. A severe peripheral diabetic neuropathy and small vessel disease caused lack of sensibility in either foot. Mr. X was discharged from the hospital with a grade III ulcer of the right foot stump necessitating daily aseptic dressing changes, evaluation of various wound treatments, and observation of his diabetes. The ulcer worsened, resulting in an amputation below the knee. Mr. X's care was denied on the grounds that it could have been rendered by a non-medical person. (Mr. X's home state does not allow aides to do the dressing care he required.)

* Miss T was a 65-year old diabetic with severe circulatory problems and gangrene of the toe. Daily wound care was denied as not medically necessary; according to the FI, three times per week would have been appropriate. Miss T was rehospitalized and her lower leg was eventually amputated.

* Mr. L was was a 76-year old in frail condition. He was bedbound with a diagnosis of pneumonia, chronic obstructive pulmonary disease, rib fractures, and flail chest. His doctor stated that daily intemittent positive pressure breathing treatments were needed due to Mr. L's severely compromised respiratory system. However, the FI denied the daily IPPB treatments for two weeks as not medically necessary. Mr. L's frail and elderly wife could not accomplish the IPPB treatments alone, however.

* Mrs. F is 80 and has just been released from a hospital with a colostomy. She is generally confused and is having difficulty learning the procedure connected with the colostomy. Her doctor ordered skilled nursing visits five times weekly for two weeks for training, but the FI has denied the visits as unwarranted.

* Mrs. C is 85 years old and has a large draining abcess of the right hip secondary to hip fracture and surgery. Wound care assessment services were provided by an RN on a daily basis for 90 days, then decreased to every other day for 34 more visits. The wound was slow in healing, and care involved wound irrigation and sterile dressing technique. Unfortunately, Mr. C's wound did not heal within the time frame the FI wanted, so more than half of the visits were denied as not reasonable and necessary.

CLAIMS DENIED BECAUSE THE CLIENT ALLEDGELY NEED MORE THAN "INTERMITTENT CARE"

* Miss H was terminally ill with a diagnosis of cancer of the colon and widespread metastasis. Skilled nursing visits were provided for administration of medication. After one week, Ms. H. was hospitalized, and she expired a month later. The home health visits were denied as not intermittent care.

* Mr. Y was also terminally ill with cancer. He suffered from severe nausea and vomiting, and his doctor ordered 1000 ml IV to run over 8 hours for three days. This treatment was then to be discontinued. The doctor did not feel the patient could safely remain at home without assessment and care by a professional nurse since Mr. Y's wife was elderly and the only other person in the house was a disabled child. The FI denied the three visits as not intermittent care.

* Mrs. P was a 90-year old woman with terminal cancer. Her family wanted to keep her at home with the assistance of a home health agency. Mrs. P suffered from constant diarrhea, resulting in eloctrolyte imbalance, dehydration, and skin breakdown. Her condition was further complicated by arteriosclerotic heart disease with variations in vital sign measurements. Medication management was a problem for both Mrs. P and her family. The FI denied Medicare benefits because Mrs. P did not need intermittent care. She died two weeks later.

* Mrs. B is an 82-year old lady, living alone, who suffered from a large invasive basal cell carcinoma of the right lower eyelid, right cheek, and right upper eyelid. She had impaired vision from cataracts and glaucoma. She required two surgeries: one for biopsies of the cancer and excision, the other involving a major plastic reconstruction with a forehead flap, mustarde rotational flap of the right cheek. Two additional procedures were required to remove nasal wires and tack up adherent eyelid tissue. Daily visits were necessary to avoid infection and possible enucleation, as hospitalization was not considered in the best interest of, or feasible for, this patient. A good result was obtained due to conscientious care. However, the FI denied numerous visits on the grounds that Mrs. B's care was "indefinite" rather than "intermittent."

CLAIMS DENIED BECAUSE THE INDIVIDUAL ALLEDGEDLY WAS NOT THOUGHT TO BE "HOMEBOUND"

* Mr. R was a cancer patient receiving radiation therapy. His weakened condition often prevented him from going to receive his treatments, and when he did go, he required the assistance of two or three individuals to help him in and out of the car. The agency's nursing visits for blood draws were denied because the FI concluded Mr. R was not homebound."

* Mrs. P, a blind, diabetic double amputee, went to renal dialysis three times weekly. Her husband carried her to the car. She was declared "not homebound."

* Mr. H was 92, legally blind, and newly on insulin. The FI determined Mr. H was not homebound because he was ambulatory with a cane within his own home. The FI had no indication that Mr. H had ever gone outside.

* The representative of one FI told a home health agency administrator that "if there is a fire in the house and the patient can get out, then the patient is not homebound."

* Miss N had end stage renal disease, diabetes mellitus, and an amputation above the right knee. Her diabetes needed to be monitored. She also required stump healing and condition monitoring with dressing changes. She was also receiving TPN nutritional therapy. Miss N left her home daily in a wheelchair for hemodialysis. Her care was denied because she was not homebound.

* Mrs. K was confined to a wheelchair because of a stroke. She was unable to care for herself at all. Her elderly husband managed to get Mrs. K to physical therapy three times a week under the orders of her physician, who thought there was a possibility of some rehabilitation. The FI said that because Mrs. K went to therapy three times weekly instead of two, she was not homebound. All of her skilled nursing and home health aide visits were denied.

CLAIMS DENIED FOR OTHER REASONS

* Mrs. M required an intramuscular antibiotic twice daily for 10 days per doctor's orders for treatment of an infection unresponsive to other methods of treatment. The FI denied the second visit each day without requesting the records or the doctor's orders, incorrectly declaring that only one visit daily was permissible under HIM-11.

* Mr. S received daily visits for two weeks for treatment of open wounds in the groin area. During the third week, the FI disallowed two of 5 visits despite documentation of continued open areas with purulent drainage. The patient was unable to reach these areas for dressing changes and no one else was available to provide care. The FI declared the two visits "not reasonable and necessary."

* Mr. G is a bed patient with continuous oxygen. He has had bruising for no apparent reason. Nurse visits were denied under the "skilled nursing" requirements, and all aide visits were denied as technical denials; this despite the fact that Mr. G has no one else in the home during the day to look after him.

* Miss J was receiving medication for a urinary tract infection. The visit made by the nurse where it was determined that Miss J was having no further symptoms was denied as not skilled service. Aide visits were accordingly denied as technical denials.

In short, there is compelling evidence that there has been an on-going effort to restrict the Medicare home care benefit and that this restriction has had devastating results for Medicare beneficiaries, for their families and for the caregivers who serve them. HCFA and ORB, not satisfied with the savings achieved in forcing DRG reimbursement on hospitals, have failed to recognize one consequence of their actions would be to increase the number of patients discharged quicker and sicker into the care of home health agencies. Instead, they have tried to "trim the candle at both ends" -- meaning an effort has been made to reduce Medicare expenditures for home health care. In this way, HCFA and its parent, the Department of Health and Human Services, have arbitrarily acted to limit the Medicare entitlement created by the Congress. It is the contention of this report that only Congress has this right and that HCFA's effort amounts to an inappropriate and unlawful intrusion into the Congressional prerogative.

01. EVIDENCE OF THE COST EFFECTIVENESS OF HOME CARE

One of the major issues involving home care is the question of whether it is cost-effective. The answer, of course, depends on the precise manner in which the question is phrased.

If the question is whether home care is less expensive when compared to treatment in a hospital, the answer is yes. The savings which have been achieved through use of DRG reimbursement have, by definition, been made possible by moving patients from hospitals to less expensive community-based home care services. Hospital care is so costly, vis-a-vis home care, that there will almost always be significant savings if the patient can be cared for in his or her own home.

The extreme case which illustrates the point is pediatric home care. Millions of children who were born with birth defects and related problems now survive because of modern technology. They remain dependent on this technology sometimes literally for every breath they take. Up until the last two or three years, this technology has only been available in the hospital. It goes without saying that the technology is expensive. Hospital bills in excess of $1 million are not uncommon. The average cost of caring for some of the children with the most serious problems, e.g., those who are respirator-dependent, is about $250,000 a year.

The same technology now has been miniaturized. It is portable and allows the care of these fragile children in their own homes for a fraction of the cost of their hospital stay. The average cost to care for such children at home runs from $20,000 to $40,000 a year. In other words, it is roughly one-tenth (or at worst, one fifth) of the cost of comparable care in a hospital.

However, what is implied in the above equation is that home care agencies will be properly equipped and trained to provide high quality services. The technology is new, and thorough training and supervision is required.

If the question is: Can all 1.3 million people housed in nursing homes today be served less expensively through home care, the answer is no.

Individuals who are housed in nursing homes tend to be very old. They have an average age of 85 and they suffer from multiple disabilities. Some of the individuals undoubtedly could be cared for at home at less cost, but not the majority of the patients. Nursing home patients have a multiplicity of problems which tend to be chronic with acute flare-ups from time to time. The cost of caring for these patients on a one-to-one basis would be staggering. Often patients decline and have even more intensive needs following institutionalization. The key to cost-effectiveness here is case management and intervening in time to prevent clients from becoming so totally disabled.

If the question is whether government could save money by establishing some kind of screening mechanism at the point of entry to a nursing home, the answer is yes, depending, of course, on the amount of administrative costs involved in the screening. If efficiently run, the mechanism will save money for the taxpayer. The danger is, of course, that the mechanism will serve to block the receipt of services by some individuals who need them.

The most compelling evidence comes from the State of New York's Nursing Home Without Walls Program (NHWW). The program, which began as a pilot in 1978, has been expanded slowly and carefully. Under the program, caseworkers and home health agencies together evaluate patients about to be placed in nursing homes. If the home health agency agrees that it can provide care for the individual in his or her own home for 75 percent of the average state Medicaid nursing home payment, the individual is placed with the agency. The home health agency can provide any mix of services that it finds appropriate--medical, nursing or social.

A January 1, 1986 health bulletin from the New York State Senate Health Committee notes:

> "The Nursing Home Without Walls Program has consistently demonstrated that it can care for patients at substantially less cost than institutional care. Since its inception, NHWW experience has shown that the cost of services for patients in the program has been approximately 50 percent of the cost of institutional care." (emphasis added).

If the question is whether expanding the scope of existing health care programs to pay for home care will result in cost savings, the answer is yes and no. It will result in greater expenditures in the short run as America tries to meet the pent up demand. The issue is analogous to a company which suddenly makes group dental insurance available to all its employees. The company can expect high utilization in the first few years, but thereafter, costs will level off. It can be argued that there are cost savings which come from maintaining the elderly in their own homes, preventing or postponing the need for institutionalization. It is also arguable that the cost to society of not helping those in need on a timely basis is significant. In the long run, the taxpayers and government will save money.

As is noted above, the question of cost-effectiveness of home care is really several different questions. This explains why the GAO noted in their examination of the research that the data was inconclusive. They said there was a lack of comparability across projects, methodological problems haunted some, and bias was apparent on the part of those doing some of the studies.

It is suggested that the best evidence which exists on the questions posed come from three sources:

1. The experience of private health insurance companies many of whom have performed detailed analyses.

2. Findings of State Governments such as the report on the Nursing Home Without Walls program cited above.

3. The judgments of experts.

This is not to suggest that studies by professional organizations such as NAHC or by the Department of Health and Human Services are without value. The contrary is true, but neither are free from suspicions of bias. There is without doubt a strong incentive on the part of the former to imply cost effectiveness and on the part of the latter to rebut it in the name of reduction of Federal expenditures.

What follows in this section is an enumeration of some of the studies which have found home care cost effective. One which deserves to be highlighted is the July 23, 1985 statement by Bernard Tresnowski, President of the Blue Cross and Blue Shield Association which says in part, "Nine out of 10 Blue Cross and Blue Shield plans now offer home health coverage as an answer to higher health care costs." As will be seen below, several of the individual Blue Cross plans have conducted studies which verify this conclusion.

The bottom line seems to be that although no blanket statement can be made that home care is more cost effective in every case, there is growing evidence that it may be so in the great majority of cases. From a cost effectiveness and from a public policy point of view, the reasons in support of the extension of existing home care benefits to other populations become more compelling by the day.

Following are some specific findings from various reports, followed by the opinions of experts.

A. SUMMARIES OF MAJOR STUDIES

SOME EVIDENCE OF THE COST-EFFECTIVENESS OF HOMECARE

(1) The American Association for Respiratory Therapy issued a report in February, 1984 finding the average cost of care for ventilator-dependent persons to be $270,830 a year per person in a hospital compared to $21,192 per person per year at home. For an example of the cost-effectiveness of pediatric home care, see the May, 1985 issue of CARING magazine.

(2) Blue Cross/Blue Shield of Maryland reported a savings of $1.2 million in 1982 from its Coordinated Home Care Program, largely by reducing the average subscriber's inpatient day stay by 8.9 days. Since 1973 the Blue Cross program has reported a net savings of $6.3 million for the program.

(3) Aetna Life and Casualty has reported a $60,000 per case savings an average from its Individual Care Management Program by using home care for victims of catastrophic accidents and illnesses.

(4) Aetna Life and Casualty Company has reported the following savings, by diagnosis, from home care versus hospital care:

Diagnosis	Acute care cost per month in hospital	Alternate care cost per month at home	Savings per month
Baby born with breathing and feeding problems	$ 60,970	$ 20,209	$ 40,761
Spinal cord injury with quadraplegia	23,862	13,931	9,931
Neurological disorder with respiratory problems	17,783	196*	17,587
Severe cerebral palsy with uncontrolled seizure disorder	8,425	4,867**	3,558

* After initial cost of equipment ** In extended care unit of hospital

DATA: AETNA LIFE & CASUALTY COMPANY (See May 28, 1984, Business Week magazine)

(5) A 1980 study by the VNA of Greater St. Louis (Missouri) of Blue Cross referrals found use of home care saved over $3,000 per patient. (See Berry, N. & S. Petit, "Home Care for Blue Cross Insured Patients: A Care Study," Home Health Review, Vol. III, No. 4, December, 1980)

(6) Blue Cross and Blue Shield of Rhode Island has reported that between 1982-83, home care allowed Rhode Island suscribers to avoid 20,050 hospital days. That is the equivalent of 61 hospital beds that were not added to Rhode Island's health care system. Translated into dollars, that means a savings of $6.1 million.

Blue Cross said that about 70% of its home care patients are being treated for orthopedic disorders, cancer, and cardiovascular conditions. Utilization of the home care benefit has grown from about 1.3% of Rhode Island Blue Cross and Blue Shield subscribers in 1979 to about 2.2% in 1983. The growth occurred despite a drop in hospital discharges.

(7) The Long Term Home Health Care Program in New York State (LTHHCP) has been operating since 1978 and has shown the cost of services for patients in the program approximates 50% of the cost of corresponding institutional care. The program is designed to provide home care services to eligible Medicaid patients who would otherwise have to be institutionalized. LTHHCP provides hospitals, nursing homes and home health agencies the opportunity to offer a wide range of services, especially coordinated case management, on a long-term basis. This includes certain medical and non-medical services necessary to maintain patients at home over long periods of time which have been available under traditional Medicare or Medicaid only in institutional settings.

(8) Ninety percent of Blue Cross and Blue Shield plans now cover home health care in an effort to contain health care costs, according to a July, 1985 survey by the Blue Cross and Blue Shield Association (BC/BSA). Home health coverage allows patients to leave the hospital and continue treatment in a low-cost home setting, according to Bernard R. Tresnowski, BC/BSA president.

A recent drop in hospital admissions and length of stay among Blue Cross subscribers is partly a result of the greater availability of home health coverage, he said. Patients covered by the Blues are spending an average of 16.7% fewer hospital days than they did last year. While hospital costs average $350 to $400 per day, home care treatments cost $25 to $75, depending on the type of care the patient needs, Mr. Tresnowski said.

Blue Cross and Blue Shield plans typically pay for physician visits, skilled nursing care, speech and occupational therapy, respiratroy care, and home health aide visits. Most plans cover antibiotic therapy and parenteral nutrition therapy administered at home. Most plans cover home chemotherapy treatments.

(9) In 1985, Blue Cross and Blue Shield of Vermont expanded its hospice coverage program statewide and expanded its home-care-oriented early maternity discharge program in addition to initiating other programs to contain institutional health care costs. The hospice coverage program began in 1981 as a pilot program and has resulted in an average length of stay of 36 days at an average cost-per-day of $36.30. This compares to an average hospital room cost-per-day of $440.

The early maternity discharge program has become so popular that BC/BS of Vermont has doubled the incentives. In 1983, the plan began offering $50 payments to mothers who participated in the Maternal-Infant Early Discharge Program. As of July 1, 1985, that incentive was increased to $100. In addition to the bonus payment, the program offers new mothers three skilled nursing visits at home and nine hours of homemaker services by participating Visiting Nurse Associations. Eligible mothers also can be reimbursed for up to $50 of the cost of taking an approved prenatal course. The Plan estimates an average savings of $700 per case for early discharge of mothers and newborn babies, "and the savings add up quickly, since maternal care is the single greatest reason for hospital admission in Vermont."

About 250 women have taken part in Vermont's early discharge program since its inception, saving an estimated $175,000 in medical costs. Nationally, Blue Cross and Blue Shield Plans pay for more than one million births a year, one-half of which are normal, uncomplicated deliveries. Officials have estimated if the average three-day hospital stay were reduced by one-half day, it would save between $40 million and $50 million annually. Fifteen Blue Cross and Blue Shield Plans are involved in various short-term maternity stay programs.

(10) A joint cost-containment venture between Blue Cross of Greater Philadelphia, Pennsylvania Blue Shield, and the Philadelphia Council of the AFL-CIO has saved an estimated $31.1 million in health care costs for union members in five local counties. The program involved various cost control measures aimed at reducing hospital utilization. These included preadmission testing, ambulatory surgery, home health care, and coordination of benefits to provide for other party liability. David S. Markson, Blue Cross Plan president, and Edward F. Toohey, labor council president, together called the report "the most comprehensive analysis of hospital utilization in the nation." The report was issued in June, 1985, and entitled "A Union For Strength in Cost Containment."

(11) Research on the Five Hospitals Homebound Elderly Program (FHHEP-Chicago, Illinois) by Dr. Susan Hughes of Northwestern University found that over a four-year period the mean cost per FHHEP patient was $2,277.33/year (in 1980 dollars) compared to $11-$13,000/year being charged in Chicago area nursing homes at the time.

Dr. Hughes' research also tracked a sample of 122 experimental FHHEP clients and 123 control clients (from elderly, homebound, OAA Title III home-delivered meal clients) and found:

- 13% of the FHHEP clients were admitted to institutions versus 23% in the control group.

- o No increase in the use of hospital services in either group despite the fact FHHEP clients were older and medically underserved at the outset of the study.

- o No difference in mortality rates despite the fact FHHEP clients were an average of three years older and more impaired at the outset of the study.

- o A slight increase in the perception of social, mental, and physical well-being of FHHEP clients versus the control group.

For more detail on the FHHEP, see the August, 1983 issue of CARING magazine.

(12) One of the few cost-related studies of private sector involvement with home care was conducted by the Joint Health Cost Containment program, a project of Penjerdel Health Care Coalition.

This study explored the possibility for cost savings to employers through the expansion of home health care. A summary of key findings follows:

a. "Home health care is significant to employers because of its potential for reducing inpatient care with subsequent reduction of the employers health insurance premiums.

b. "The estimated potential savings in the Penjerdel region (Philadelphia SMSA) that could be attained with full exploitation of home health services among the employed population is approximately $19,000,000, or $8.25 per year per covered employee or dependent. Probably less than 10% of this potential is currently being realized.

c. "The clinical outcome of patients assigned to home health care programs is consistently at least as favorable as the outcomes of patients with similar diagnoses cared for in institutional settings.

d. "Obstacles to optimal utilization of home health services include: hospitals and home health care providers; unwillingness of physicians and consumers to accept use of home health care; restrictive reimbursement policies, procedures and regulatory requirements; and the bias of the health system toward institutional care.

e. "Most Blue Cross Plans offer the home health benefit as part of their basic coverage. Commercial insurers typically do not but will underwrite the benefit and charge an increased premium if the added coverage is requested."

(The Potential for Cost Containment Through Home Health Care, A Project of the Joint Health Cost Containment Program, Philadelphia, PA, December, 1980).

(13) The Georgia Alternative Health Service project offered alternative services for persons who would otherwise be placed in nursing home care institutions. The model was built on a centralized point of entry into all service systems. In addition to regularly financed Medicaid services, three alternative services included were adult day rehabilitation, home-delivered meals and alternative living arrangements.

Highlights from preliminary findings included:

- Medicaid nursing home costs are on the average 33% higher for the control group than for the experimental group.

- Physician costs reimbursed by Medicaid are 141% higher for the control group than for the experimental group.

- Mean Medicaid inpatient hospital costs are 49% higher for the control group than for the experimental group.

(See Skellie, F.A., American Journal of Public Health, April 1982)

(14) In Monroe County (Rochester, New York), the ACCESS program includes pre-admission assessments for adults at risk of long-term care. The comprehensive evaluation considers medical, nursing, and psychosocial needs. During 1977, Medicaid costs for all direct non-institutional services provided after assessment to skilled level patients were estimated at 52% of the comparable Medicaid institutional rate. Average monthly costs for aged and disabled Medicaid beneficiaries increased by 12% in Monroe County when in six comparison counties they increased 17%.

(See Eggert, G., et.al. "Gaining Control of the Long Term Care System: First Returns from the Access Experiment," Gerontologist, 20(3), - June, 1980).

More recent data on Phase I and Phase II of ACCESS shows even more cost-effectiveness results (see CARING magazine, December, 1984).

(15) A four-year study (1979-1982) of the On Lok Senior Health Services (San Francisco, CA) Community Care Organization for Dependent Adults program (CCODA) found that average per capita cost of health care services for the Comparison Group was 26% higher than for the CCODA Group. Even with adjustment for community living expenses such as housing and meals, the total long term care cost (both public and private sectors) for the Comparison Group was still 12% higher than for the CCODA. While individual costs rose over time in both Groups, the CCODA Group's cost increased less than the Comparison Group's.

The CCODA program manages and delivers all long term care services to its clients, including community-based outpatient services, home care, acute hospitalization, nursing home care and housing assistance.

(16) In Florida, cost savings were identified in a program that provides community care for persons 60 years of age or older who are functionally impaired and eligible for nursing home services. Cost per client in 1979, including food stamps and SSI payments, were between $232 and $261 per month in the experimental group; nursing home care for Medicaid patients ranged between $455 and $641 and costs in congregate living facilities and foster homes were $288 and $334, respectively.

(See "Evaluation Report-Phase I, Florida's Community Care for the Elderly Program", Office of the Inspector General, Office of Evaluation, Florida Department of Health and Rehabilitation Services, November, 1980).

(17) In July 9, 1985 testimony before the U.S. House Select Committee on Aging, Florida Governor Robert Graham reported that in 1984 the average Medicaid nursing home care cost was $12,000 per patient compared to a $3,400 per patient cost under the state's Medicaid 2176 waiver program.

(18) In Utah, a statewide program of alternative services focused on persons applying for nursing home admissions for non-medical reasons achieved a 25% reduction in state expenditures for nursing home care. Cost per client day in 1978-79 was about $8 compared to costs of $24-33 for daily nursing home care.

(See Haglund, Richard F. "Final Evaluation Report of the Alternatives Program for the Edlerly," Salt Lake City, Utah: Management Resource Associates 1979).

(19) In the Cape Ann-North Shore area of Massachusetts, a screening activity denied or diverted from institutional care about 14% of requests for approval of nursing home placements. The number of applicants served in the community might have been increased more than fourfold if adequate services were available. Community placements at $10.00 a day in 1979 cost all public payors $4.32-9.07 less per day of care than nursing home placements.

(See Saphire-Bernstein, Inger and Ogietree, Ann M. "The Case Management Screening Project, Project Description and Report of Results." Beverly, Mass.: Mass. Department of Public Welfare, August 24, 1978-February 29, 1980.")

(20) In Virginia, a statewide pre-admission screening program for Medicaid nursing home applicants reduced placements 20% during 1977-80. Potential average savings of $560 per patient per month was estimated by maintaining individuals in the community. It was estimated that the rate of disapprovals of nursing home placements could have been increased to 35-40% if adequate community services were available.

(See Knowlton, J., et.al. "Nursing Home Pre-Admission Screening: A Review of State Programs," Health Care Financing Review 3 - March, 1983).

(21) In Washington, a research project in two communities (and a comparison site) conducted in-depth screening and assessment of designated high risk clients. A significant reduction in the rate of nursing home use was achieved. Only about 10% of all high-rise patients were estimated to cost more to serve in the community than in nursing homes. The study report indicated that total costs could have been reduced if more stringent requirements -- for instance, if the likelihood of admission was greater -- had been applied to patients considered at high risk of nursing home placement and if services had been focused on that group.

(See Solem, Roberts, et.al. "Community-Based Care Systems for the Functionally Disabled: A Project in Independent Living," Analysis and Information Services Division and Bureau of Community and Residential Care, Department of Social and Health Services, Olympia, Washington, July, 1979).

(22) In Connecticut, the second phase of the Triage project focused on persons at high risk of institutionalization. A 1982 report indicated that fewer Triage clients entered skilled nursing facilities than did members of the comparison group and they had fewer days of care during this period.

(See Nocks, B, et.al. "The Effects of a Community-Based Long-Term Care Project on Nursing Home Utilization," Paper presented at the 35th Annual Scientific Meeting of the Gerontological Society of Amercia, Boston, Massachusetts, November, 1982).

(23) In Arkansas, a program on in-home services for frail, vulnerable elderly in imminent danger of institutionaliztion produced substantial savings in public outlays. While the total costs of services, regardless of who bore those costs, for the extremely impaired clients at home were about the same as comparable patients in nursing homes, only 30% of the costs were paid from public funds whereas almost all facility costs were paid from public funds. Families and friends provided the largest portion of care to patients at home at all levels of impairment. As a result, the cost of care for an extremely impaired person was estimated at $330 per month with in-home services and more than $860 a month in a facility.

(See "The In-Home Option: An Evaluation on Non-Institutional Services for Older Arkansas." Office on Aging, Arkansas Department of Human Services, 1981.)

(24) Two projects in New York City reported savings from programs of home health care. In the Bronx, the median cost of such a program was about a fourth the cost of care in skilled nursing facilities and less than half the costs in health-related facilities. In Chelsea and Greenwich village, annualized costs of the program were 47-80% of nursing home care depending on the patients' problems. For more current information on the Chelsea program of St. Vincent's Hospital, see the July, 1984 issue of CARING.

(See, respectively, Wildemer, Geraldine, et.al. "Home Health Care - Services and Cost," Nursing Outlook (26(8) - August, 1978; and Brickner, P.W. "Health Care Services for Homebound Aged Maintain Independence, Limits Costs," Hospital Program, 61(9), September, 1980).

(25) A study in six cities of the effects and costs of day care and homemaker services for the chronically ill found that, while the addition of the new services covered in this study increased overall outlays for Medicare and Medicaid, for certain sub-groups institutional services were reduced. Skilled nursing days were lower for (1) patients receiving day care; (2) patients receiving homemaker services who had minimal dependency needs and those with a diagnosis of circulatory diseases; and (3) patients receiving combined services.

(See Weissert, W., et.al. "Effects and Costs of Day Care and Homemaker Services for the Chronically Ill," Department of Health Services Research DHEW Publication No. (PHS) 79-3258, February , 1980.)

(26) The Gateway II Project (Maryland) found on the average, community-based care for a Gateway II client who receives gap-filling funds costs the state a total of $222 per month. This amount includes gap-filling service funds and state funds spent for other services. If the same client entered a nursing home, the costs to the state for nursing home care would be $482 per month. The new savings to the state of community care is $260 per person per month.

Total public costs for average Gateway II client receiving gap-filling services are $398 per month including local, state, and federal costs. If the same client entered a nursing home his care would cost the public $959 per month. (See May, 1984, CARING magazine).

B. OPINIONS OF EXPERTS

Following are quotations from Members of Congress and other notables who have expressed their opinion that home care is less costly as well as the preferred health care alternative:

- "Limiting the use of the home health benefit could well be penny wise and pound foolish if failure to provide home care results in increased hospital and nursing home costs."

  Senator John Heinz (R-PA), Chairman
  Special Committee on Aging

- "The availability of nursing care from home health agencies has provided many patients with the option to remain at home, while at the same time, in most cases, home health costs less than that delivered in an institutional setting."

  Congressman Bill Gray (D-PA), Chairman
  Budget Committee

- "We have to start paying for home health care in a big way in this country. In the short run it may cost a little more, but in the long run it will save a lot of money."

  Joseph A. Califano, Jr., Attorney and
  Former Secretary, U.S. Department of Health
  and Human Services

- "Home health care can result in enormous savings over the long run. Even if there weren't a savings, even if it was a little more expensive, the quality of life would be so enhanced that it would be worth what little more we had to pay."

  Senator Orrin Hatch (R-UT), Chairman
  Labor and Human Resources Committee

- "I am heartened to see the increasing interest in exploring home base alternatives to institutional care...It has been demonstrated that costs can be reduced by as much as two thirds while permitting families to be together in an intimate and humane setting."

  Senator Lloyd Bentsen (D-TX)

- "I am strongly supportive of home health care since I know it to be an effective means for keeping older people in the community and thereby avoiding more costly institutional care."

  Congresswoman Olympia Snowe (R-ME)

- "Home and community health care services enable many older people to avoid going to a nursing home at far greater cost."

  Cyril Brickfield, Executive Director
  American Association of Retired Persons

- "I think that home health care is the way to go...Home health care makes a lot more sense today with spiraling hospital costs."

  Congressman Charlie Rose (D-NC)

- "Home care is a humane program which allows the individual to remain with his family while recuperating. It is also a program which actually helps restrain health costs to the government."

  Senator Pete V. Domenici (R-NM)
  Budget Committee Chairman

- "You know old people don't like institutions. We ought to enable old folks to stay at home in familiar surroundings. And that's cheaper too."

  Ann Landers

- "Home care is a cost-effective, humane health care alternative whose time has come."

  Senator Bob Packwood
  Chairman, Finance Committee

- "The evidence is clear. Extraordinary financial savings -- measured for the nation in billions of dollars -- would be achieved if a comprehensive program of home care were developed-- one that kept the elderly out of hospitals and nursing homes or got them out and back home quicker."

  Senator Charles Percy

- "Given the 'graying of America,' it is time that we responded with a federal policy that satisfies the needs of our growing population of older Americans, while making the most efficient use of our federal dollars. Home care is clearly an element in that solution."

Congressman John R. McKernan, Jr. (R-ME)

- "Health care in America has come full circle. It originated in the home and moved to the hospital with the advent of technology and improved methods of diagnosis and treatment. However, emphasis is now turning back to the home setting as a way to control cost."

Senator Jeff Bingaman (D-NM)

- "The evidence, I think, is overwhelming that patients get along much better if they can stay in a home environment rather than being in even the best institutional environment. So from that aspect, home health care is probably the best bargain we have in this country."

Congressman Charlie Whitley (D-NC)

- "More emphasis is needed on home-based care--for cost reasons and for humanitarian reasons."

Senator Bill Bradley (D-NJ)

- "Effective use of home health services can lead to less institutional care and a reduced demand for expensive nursing home and hospital health services."

David Stockman

- "Our home health care providers' services have repeatedly demonstrated their cost-effectiveness over institutional care. In a time when cost-cutting seems to be the order of the day, it is a rare pleasure to find a program that will improve the lives of millions of Americans as well as saving our stretched health care dollars."

Senator Donald W. Reigle, Jr. (D-MI)

- "I firmly believe that home health care is an immediately available and viable method of reducing health care costs."

Senator Clairborne Pell (D-RI)

- "As health care bills in this country have continued to grow, home health care has become an increasingly cost-effective alternative to hospitalization and nursing home placement for elderly and disabled Americans."

Senator Tom Harkin (D-IA)

- "Home health care is cost-effective. It reduces health care expenses for the federal government, and provides a more financially secure future for our nation's elderly. I believe we should support the growth of this sensible alternative to institutionalized care."

Senator Steve Symms (R-ID)

- "As a sponsor of several recent changes in the Medicare law to expand home health care programs, I know that it will continue to become more and more important as hospitals look toward lower cost community care to cope with health care cost containment."

Senator Lawton Chiles (D-FL)

- "I support the home health care program because I believe it plays an important role in our efforts to achieve health care cost containment."

Senator Thad Cochran (R-MS)

- "Increasing health care costs are an impetus to our support for home health care. The savings generated by continuation and expansion of such programs cannot be overlooked, particularly in this time of fiscal restraint."

Senator Alfonse D'Amato (R-NY)

- "Given the choice of institutional or community-based care, most families prefer home health care. Furthermore, we know that home care, as a substitute for hospital or nursing home care, can save federal and state governments a considerable amount of money."

Senator John Kerry (D-MA)

- "Everybody wins with home health care. Medicare beneficiaries can receive care in their own home that helps them remain independent and self-sufficient. Medicare and the federal government save money because home health care is much less expensive than the alternative-hospital care. I have strongly supported home health care and will continue to do so."

Senator Rudy Boschwitz (R-MN)

- "Our nation's health care programs are undoubtedly the finest in the world. A prime reason for this has been our willingness to give priority to the type of cost-effective and humane care demonstrated by home health care agencies and hospice programs."

Senator Daniel K. Inouye (D-HI)

- "Home care offers an important alternative to traditional health care that allows individuals to remain at home, in familiar surroundings, during their illness or convalescence, while achieving significant cost savings."

Congressman Jack Kemp, (R-NY)

- "The current budget situation makes it imperative that home health care play an increasingly important role in providing quality, cost effective health care."

Congressman Cecil "Cec" Heftel (D-HI)

- "[illegible] [illegible] [illegible] [

- "Home health care represents one of the significant alternatives to the unsatisfactory spiral in health care costs which has had such a negative impact on our general economy."

Congressman William S. Fonz (D-WI)

- "As Congress works to control Federal spending in all areas, we should applaud home health care. Home care reduces the cost of medical care while addressing the human needs of patients."

Congressman Albert G. Bustamante (D-TX)

- "As we continue the effort to moderate the rising costs of quality health care, with primary concern for the general welfare of health care recipients, it seems a matter of common sense that quality health care at home, adequately planned and supported, could prove to be an increasingly effective and beneficial bargain."

Congressman S. French Slaughter, Jr. (R-VA)

- "The availability of nursing care from home health agencies has provided many patients with the option to remain at home, while at the same time, in most cases, home health care costs less than that delivered in an institutional setting."

Congressman Bill Gray (D-PA)

- "Because of the personal, convenient and cost-effective nature of home health care, Americans should take advantage of this opportunity as an alternative to institutionalized care."

Congressman Carroll Hubbard (D-KY)

- "The answers to cost containment and appropriate health services may increasingly be found in the proper use of home health care."

Congressman Ralph Regula (R-OH)

- "As we confront the horrible problem of rising health care costs, we have got to broaden our view. We must search for new ways of assuring quality care by less expensive means . Home care is truly a part of the solution to escalating health care costs."

Congressman Al Swift (D-WA)

- "In my opinion, home health care provides a high-quality and cost effective alternative to institutional care in this country."

Congressman Robert T. Matsui (D-CA)

- "The benefits of home health care are many. It is, in most cases, a more cost-effective method of providing care than institutionalization."

Congressman William Hughes (D-NJ)

- "The cost of home health care is more affordable to the patient and the community as a whole."

Congressman Mickey Leland (D-TX)

VII. RESULTS OF A NATIONAL OPINION SURVEY MEASURING PUBLIC ATTITUDES WITH RESPECT TO HOME CARE

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In 1985, the National Association for Home Care commissioned a national opinion (market) survey of public attitudes towards home care. The study was conducted by Dr. Marvin Cetron and Forecasting International of Arlington, Virginia.

The highlights of the survey are important to policymakers:

- Home care has a very positive image among Americans of all ages.
- It is the preferred form of health care by a wide margin over care delivered in an institutional setting.
- There is high satisfaction among the users of home care; those who have benefited from such service invariably become strong advocates for it.
- Only about 40 percent of the American public have heard about home care, but those who learn about it strongly support the concept. Over 85 percent of those who know about it support the concept.
- Home care appeals to both liberals and conservatives. Conservatives support it because it serves to keep families together and is less costly than institutional placement. Liberals support it and argue that irrespective of costs, it should be supported on humanitarian grounds.
- Support for home care is very high among minority groups such as Blacks and Asian Americans who have a strong tradition of "taking care of their own" in an extended family setting.
- The group which was most supportive of home care was Americans from 25 to 40 -- the baby boom generation. These individuals are greatly concerned about the burden of supporting children in college while simultaneously supporting parents, grandparents and perhaps even great grandparents.
- Home care is supported over nursing home care by an overwhelming margin although most people feel that good nursing homes are an essential part of the American health care system.
- The American public strongly supports legislative proposals which would broaden the scope of existing government health care programs to provide meaningful home care.
- The public strongly supports tax breaks and other incentives which would encourage family members to accept the responsibility of caring for aged relatives.

Details of the study follow:

Specifically, Forecasting International was asked to examine:

- Awareness of home care services and media coverage,
- Awareness of hospice care and support for insurance coverage,

- Attitudes toward hospital care,
- Preferences for home care versus nursing homes,
- Attitudes towards insurance coverage for long-term home care and catastrophic care,
- Acceptability of policy options for health care cost containment,
- Preferences for how to cut the federal budget,
- Attitudes toward usage of physician assistants and adequate preventive care,
- Awareness of financial responsibility for family members over 65 years of age, and
- Profiles of home care supporters

METHODOLOGY

The market research survey utilized a telephone survey method. Professional interviewers from Market Opinion Research's (MOR) Telephone Bank Division administered a questionnaire approximately 9 minutes long to a random sample of adults representing the population as a whole in terms of sex, age, racial background, incomes, and geographic distribution.

The sample consisted of 1,200 completed interviews with persons over 18 years of age. Coding, editing, weighting, and computer analysis were performed by MOR. The survey analysis included frequencies, or a count of how people answered each question, as well as a series of cross tabulations to develop demographic and home care profiles. Specifically, three special segments were created for analysis of home care supporters: (1) those "unaware" of specific home care services, (2) those "knowledgeable" but not users, and (3) those who have "used" home care or had close friends or family who have been users.

KEY HIGHLIGHTS

Only 38% of the population are able to name a home health care service that they are "aware of." Of those services named, nursing has the highest level of awareness (26%). Homemaking, home health aides, hospice, meals delivered, and physical therapy have between 7% and 2% unaided awareness.

Awareness of home care is lower than average among males, those over 65, Blacks, Hispanics, low-end income/economic group, and those in the Mountain region. Awareness is strongest among females, 55-64 age group, intelligentsia, high-income group, Jewish, and those in the New England and Pacific regions.

In the last year, only 34% of the American public have seen advertisements, special programs, or read articles on home health care services or agencies. Media awareness of home care is distinctly different from overall awareness of services among those over 65. These older Americans have a higher than average awareness level of the media in contrast to their lower than average awareness of any specific services.

Awareness of home health care is most likely to come from a family member's usage (35%), stories or media coverage (23%), or from health care professionals (18%), and least likely to come from one's own experience or usage (11%). As might be expected, those over 65 have a higher than average awareness of home care from their own usage, and those 55-64 have high awareness through a family's or friend's usage.

Home care has a very positive image (85% support) among those who have any awareness. Home care is preferred by 72% of the American public over nursing homes for the care of those persons who need frequent medical assistance and housekeeping assistance. The most dramatic support for home care over nursing homes comes from Hispanics (90%), which is in keeping with their strong family orientation.

The positive attitudes toward home care are not a result of negative experiences with hospitals, because the public thinks that hospitals are doing a "good job" of meeting the needs of the family and patient (90%). Satisfaction with hospitals is noticeably higher among the intelligentsia and lower for the low-end income/economic group.

When asked, 26% of the public are able to correctly identify that hospice services help the terminally ill. A majority (64%) think that hospice services should be covered by insurance, but only 46% say they would pay a higher fee for such coverage now. Awareness of what hospice services provide is extremely low among Blacks (12%) and Hispanics (5%); however, they are very strong supporters of hospice insurance coverage after hearing a definition of hospice care. A majority (65%) think long-term home care should be covered by insurance and even more people (73%) support the coverage of catastrophic medical care.

Willingness to pay for hospice coverage declines with age, as does support for insurance coverage for hospice care, home care for long-term illness, and catastrophic care. Democrats more than Republicans tend to support insurance coverage for these three areas.

Acceptable ways of controlling the rapid increases in health care costs are those which do not impact the individual's pocketbook or personal freedoms very directly:

- Insurance plans that encourage the care of chronically ill at home (85%),
- A system that encourages the use of physician assistants, nurse practitioners and midwives (76%);
- Requiring employees to pay a part of their health insurance premiums (74%), and
- Price controls on doctors' and hospitals' fees (71%).

Among the sample surveyed, it is not acceptable to require people to pay a larger portion of their medical fees covered by insurance (32%) or to have more insurance plans that designate which doctors can be consulted (38%).

People who have had experience with home care themselves (or through family or close friends) are more supportive of home care than those who have little or no awareness of home care. However, the people most supportive of home care are what we call the "knowledgeable" group. They are knowledgeable about home care but have not had experience with it. Those knowledgeable are well-educated, and may or may not have high incomes. The group consists of slightly more females than males, and has a high proportion of people aged 25-34.

CONCLUSIONS

Home care has a positive image but suffers from low awareness, particularly among those 65 years of age and those with lower incomes and less education. Men are somewhat less familiar with home care than women, and thus less supportive.

Conceptually, the American public thinks that home care is a better way to care for those who need frequent medical and homemaking assistance than in nursing homes, even though they have little awareness of the actual services provided by home care. This attitude does not stem from dissatisfaction with recent hosptial experiences.

Only one-quarter of the public knows what hospices are; but when given an explanation of hospice services, the majority support coverage by insurance. Likewise, the majority support coverage of long-term home care and catastrophic care. Naturally, fewer people are willing to pay higher insurance fees for coverage of hospice care.

The most acceptable ways of controlling health care costs are those options which do not affect the individual's pocketbook very much or his freedom to choose his own doctor; home care for the chronically ill, use of professional assistants to doctors; employees paying part of insurance premiums, and price controls on doctors' and hospitals' fees are acceptable.

The public does not feel that all of the "fat" in the federal budget is in defense. People are split between cutting the budget more from defense or spreading the cuts equally between defense and Social Security/Entitlement programs.

One can surmise that, until a crisis occurs, few people feel an immediate financial responsibility for a family member over 65.

Americans think they are receiving very adequate preventive health care information, even though health care dollars rarely go to such areas. Those most supportive and knowledgeable about health care are less positive than others about the preventive care they receive and perhaps more aware of what preventive care should be.

To date, home care is supported most by upper income, highly educated, slightly younger Americans rather than by many of its beneficiaries -- older Americans. A subgroup which often emerges as most supportive is the intelligentsia, who are characterized as college graduates, earning less than $40,000, and somewhat younger.

The two major minority groups, Hispanics and Blacks, are very supportive of home care but often less aware of its services than the general population. This is related most likely to their lower income and education levels as a group, rather than reflecting a true variation in awareness levels.

The future of health care is one of the most crucial issues facing America today. Problems of spiraling costs, limited nursing home space, and inadequate insurance coverage will become more acute as our elderly population continues to increase in number. These factors make home care a vital component of health care in the future -- not only to ease the cost burden, but to ease the burdens of the aged.

Home care allows older Americans to remain in their own homes, surrounded by family and friends, living as independently as possible, while receiving quality medical care on a regular basis. Home care is essential in the care of chronically ill children; it keeps families where they should be -- together. Health improves much faster in positive social environments--and what could be more positive an environment than one's own home, where personalized care is provided by professionals, as well as relatives and friends?

Home care provides a much preferred alternative to our present practice of institutionalized care and is the hub of our future system of community-based health care.

Home care is like a relatively new service for most people. Typically, social innovators, who are well-educated and in higher income brackets, are the first to use new services. To move past this early adoption state into widespread support and usage, public awareness and education efforts are a critical next step.

VIII. A SHORT LIST OF THE REASONS IN FAVOR OF HOME CARE

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More and more Americans every year are receiving their health care services at home. The move towards home care is being fueled by a multiplicity of factors. First is the growing public recognition of, and demand for, home care. Second, the growth in the number of agencies has made home care more generally available. Third, new technological advances have made it possible to deliver complex care at home which previously was available only in an institution. Fourth, the growing number of older Americans who are living longer are increasingly in need of home care services in order to remain independent in their own homes. Finally, there are cost considerations. The premise behind prospective (DRG) payment to Medicare participating hospitals is that patients' stays in the hospital would be reduced by sending them to less costly community-based facilities for part of their convalescence. Clearly, hospital stays have been reduced, and patients are being discharged quicker and sicker into the custody of home health agencies.

The central premise of this report is that rather than accept some modest increased costs in Medicare's home care expenditures, HHS has perversely sought to reduce expenditures for home care. The inevitable result of these two forces, increased demand for home care and simultaneous reduction in expenditure, is undoubtedly a collision. In the short run, the result will be that thousands of older Americans will go without the home care services that they need. In the long run, the crisis this precipitates will result by necessity in the formulation of comprehensive long-term care policy based upon home health care.

Following is a short list of the public policy reasons in support of home care. The list is compelling. The logic in favor of making home care the first line of any health delivery system is overwhelming. In this connection, valuable lessons can be learned from the British, Canadian and the Scandanavian countries, which have made it the centerpiece of their health delivery systems.

Home care (which includes home health care, homemaker/home health aide and hospice services) is desirable because:

1. **It is delivered at home.** There are positive feelings all of us associate with being home. Our home is our castle, our refuge from the storm. When we are not feeling well, most of us ask to go home. When we are feeling well, we enjoy the sanctity of our residences and the joy of being with our loved ones.

2. **Home care represents the best tradition in American health care.** Home health agencies were started as public agencies to seek out the poor and the needy who otherwise would go without care. No one was turned away. This is still true for most of America's home health agencies.

3. **Home care keeps families together.** There is no more important social value. It is particularly important in time of illness.

4. **Home care serves to keep the elderly in independence.** None of us wants to be totally dependent and helpless. With some assistance, seniors can continue to function as viable members of society.

5. **Home care prevents or postpones institutionalization.** None of us wants to be placed in a nursing home unless this is the only place where we can obtain the total, 24-hour care that we need.

6. **Home care promotes healing.** There is scientific evidence that patients heal more quickly at home.

7. **Home care is safer.** For all of its lifesaving potential, statistics show that a hospital is a dangerous place. The risk of infection, for example, is high. It is not uncommon for patients to develop new health problems as a result of being hospitalized. These risks are eliminated when care is given at home.

8. **Home care allows a maximum amount of freedom for the individual.** A hospital of necessity is a regimented, regulated environment. The same is true of a nursing home. Upon admission to either, an individual is required to surrender a significant portion of his rights in the name of the common good. Such sacrifices are not required at home.

9. **Home care is personalized care.** Home care is tailored to the needs of each individual. It is delivered on a one-on-one basis.

10. **Home care, by definition, involves the individual and the family in the care that is delivered.** The patient and his family are taught to participate in their health care. They are taught how to get well and how to stay that way.

12. **Home care reduces stress.** Unlike most forms of health care, which can increase anxiety and stress, home care has the opposite effect.

13. **Home care is the most efficient form of health care.** By bringing health services home, the patient does not generate board and room expenses. The patient and/or his family supply the food and tend to the individual's other needs. Technology has now been developed to the point where almost any service which is available in a hospital can be offered at home.

14. **Home care is given by special people.** By and large, employees of home health agencies look at their work not as a job or a profession, but as a calling. Home care workers are highly trained and seem to share a certain reverence for life.

15. **Home care is the only way to reach some people.** Home health care has its roots in the early 1900's when some method was needed to provide care for the flood of immigrants who populated our major cities. These individuals usually did not speak English, had little money, and did not understand American medicine. The same condition exists now to some extent because of the new wave of immigrants and the large number of homeless individuals who roam our streets.

16. **There is little fraud and abuse associated with home care.** Other parts of the health care delivery system have been riddled with fraud and charges of poor care. There have been few, if any, major scandals related to home care.

17. **Home care improves the quality of life.** Home care helps not only add years to life, but life to years. People receiving home care get along better. It is a proven fact.

18. **Home care is less expensive than other forms of care.** The evidence is overwhelming that home care is less expensive than other forms of care. Home care costs only one-tenth as much as hospitalization and only one-fourth as much as nursing home placement to deal with comparable health problems.

19. **Home care extends life.** The U.S. General Accounting Office has established beyond doubt that those people receiving home care lived longer and enjoyed living.

20. **Home care is the preferred form of care, even for individuals who are terminally ill.** There is growing public acceptance and demand for hospice care, which is home care for individuals who are terminally ill.

In short, home care is the oldest form of health care; health care has been traditionally given at home throughout the centuries. It is also the newest. Modern technology has developed to the point where virtually anything which is available in a hospital can be provided at home. There is significant evidence that it is less costly than other forms of care and that it is the most satisfying form of health care available to the American public. Little wonder that the public is demanding that it be made more available. It is an idea whose time is come.

II. [illegible]

[illegible]

At the present time, there is a great deal of public attention on the need for catastrophic health insurance coverage. Officials representing the Administration and the Congress have talked about the need to protect older Americans.

There is also increased attention on the need for long term care. Long term care is the single greatest health concern of the elderly according to the American Association of Retired Persons.

There is also a great deal of concern about patients who are discharged quicker and sicker from hospitals. Some individuals apparently have been discharged sooner than was desirable and others have needed to be rehospitalized.

Then there is growing concern about the thousands of children who continue to live in hospitals when they could be cared for at home. Finally, there is continuing concern about the escalating cost of health care. The central issue is how to use existing dollars to cover more health care for more people.

Home health care connects with all of these issues. It is one answer to the dilemma of how to help people and save money at the same time.

Home care is the answer of choice for families who have fragile and technologically-dependent children. Home care is the means of intervening to postpone or to prevent the need for institutionalization.

Home care is, has been, and should continue to be, the central core of any policy of long-term care in this country.

Home care should also be the core of any national effort to provide catastrophic health protection.

Home care has the potential of solving many of the nation's health care problems. It enjoys high and growing acceptance among the population. There is very high satisfaction among those who have used the service.

As a reflection of this fact, home care has benefited from wide and growing support among the Congress. This support extends to both Democrats and Republicans, conservatives, as well as liberals.

Virtually, the only center of resistance to home care rests in the Office of Management and Budget, and the influence it carries in the Department of Health and Human Services.

Spurred by [illegible], OMB has sought by a series of extraordinary, arbitrary, and capricious, illegal measures to restrict the growth of home care. The primary reason appears to be a desire to restrict Medicare payments in general and the growth of home health care specifically. Home health care does stand out because it is the fastest growing part of Medicare.

documentation which has served only to increase costs. It has insisted on the use of forms which have been cumbersome and maldesigned which have lead only to increased red tape.

Simultaneously, it has increased pressure on intermediaries to audit home health agencies and to find what it terms "inappropriate care." HHS requires intermediaries to find at least $5 in disallowed claims for every $1 it spends in an auditor's salary. Intermediaries which fail to meet this standard are in danger of losing their contract with the Government.

The results have been a slow down in payment which has created severe cash flow problems for agencies.

Home health agencies have been informed that they cannot help senior citizens appeal Medicare claims which have been denied. The effect of this, of course, has been to reduce the level of appropriated expenditures to Medicare beneficiaries.

Costs properly attributed to the Medicare program have been unfairly shifted to other sources of payment. Medicare has denied payment altogether for relatives who have chosen to supplement Medicare's payment by hiring additional personnel to provide nursing or other home care for their relatives.

It has required all home health agencies to post a bond absent any evidence of potential default.

HHS recently published rules to slow down the growth in agencies by eliminating return on equity for for-profit agencies and doing away with special exceptions to its cost limits for newly established agencies.

Last July, HHS announced rules which dramatically changed the manner in which home health agencies are to be reimbursed. The present law currently reimburses home health agencies for up to 75% of their aggregate costs. The new rules would establish a limit of 120% of the mean by discipline. The new rule is the equivalent of a drop to 70% with automatic ratcheting down targeted to the 65th and 60th percentile in each successive year. The new rules, unless Congress intervenes, would also bar efficient agencies from aggregating costs which means they would no longer be allowed to use savings in one area of service to subsidize higher cost in another.

On top of these and other measures detailed in Section IV of this report HHS has now proposed a 1% across-the-board cut in expenditures to hospitals, home health agencies, and all of the providers. This cut appears to be equitable but it really is not. Home health agencies have been the target of significant administrative cuts and the new HHS mandate would have a significant and double impact on home health agencies who have already faced severe administrative cuts.

Secondly, the across-the-board deductions do not take into consideration the unique nature of cost-based reimbursement. The effect of a 1% reduction on cost risk based reimbursement, in this instance, is to put home health agencies into a negative spiral where they are required to provide services and to accept in reimbursement 1% less than cost for every visit that they make.

The accumulated effect of these measures has been devastating. For over 100 years home health care has been one of the most positive parts of the American health care system. But that tradition is now in jeopardy. Unless Congress intervenes, DHHS will have effectively dismantled the Medicare home care benefit.

X. RECOMMENDATIONS

X. RECOMMENDATIONS

Following is a list of proposed solutions to the problems identified in this report. These recommendations are offered for the consideration of the Congress. In general, NAHC endorses the recommendations of the House Committee on Aging, Subcommittee on Long-Term Care and their December, 1984 report "Building Long-Term Care Policy".

1. Congress is urged to enact legislation requiring the Department of Health and Human Services (HHS) to comply with the Federal Administrative Procedure Act. There is strong evidence on the record that HHS has acted arbitrarily, that it has reduced the value of the Medicare entitlement, and that it has crossed the line between policy making, which is the prerogative of the Congress, and policy implementation.

2. Congress should establish within HHS an internal Office of Management and Budget. Such an office had existed, and was dismantled recently, leaving HHS under the control and domination of the Office of Management and Budget. HHS needs its own experts if the Secretary and other personnel are going to be able to carry out the duties for which they are responsible by statute.

3. Congress is asked to intervene to block the unintended double blows that will occur if the reductions in expenditures because of new controls targeted at home health are combined with the Gramm-Rudman directed reductions. An amendment to Gramm-Rudman which reduces its cuts in recognition of regulatory action taken toward the same ends would be desirable.

4. Congress should consider exempting home health agencies (HHAs) from the Gramm-Rudman cuts and/or making reductions in a more equitable manner, one which takes into consideration the unfair effect of including within across-the-board reductions applicable to block grants reductions in cost-based reimbursements.

5. Congress should immediately enact provisions agreed upon in 1985 by the House Ways and Means Committee and the Senate Finance Committee which released agencies from the July 1, 1985 HHS regulations changing the formula for computing cost limits applicable to agencies.

   The new rules barred agencies who were efficient from using savings in one area of service (e.g., nursing) to provide service in another area (e.g., physical therapy). This principle is called aggregation. The proposal as passed by the Senate would allow agencies to aggregate costs, at the same time preserving reductions in overall cost caps applicable to those agencies which had been mandated by HHS.

6. Congress should once again reject the Administration's proposal to add a 5% coinsurance to the home care benefit. Congress removed this impediment long ago in order to encourage utilization. Since much of the increased utilization of home care in the last 2 years has been a result of DRGs, coinsurance will do nothing to slow down utilization. Coinsurance is simply a tax on beneficiaries which would cost the government more to collect than it would save.

7. Congress should amend the provision in the Medicare law which limits those receiving home care to those needing "intermittent care." It is a cruel hoax to tell the elderly that they cannot be cared for because they need too much care and are too sick, and therefore, belong in a nursing home, knowing that Medicare pays for a very limited amount of such nursing home care. Only about 7,000 of the 1.3 million patients in nursing homes on any given day have their care paid for by Medicare, and their reimbursed stays tend to be very short--an average of 25 to 30 days. If the Congress insists on limiting the home care benefit, there are better ways to do so. NAHC has endorsed HR 2371, introduced by Congressman Henry Waxman, which would make it clear that the term "intermittent" would not block the care of individuals who otherwise qualify for daily visits up to 90 days.

8. Congress should enact legislation introduced by Congressman Ron Wyden which clarifies the right of providers to assist Medicare beneficiaries in appealing claims that have been denied by Medicare.

9. Congress should block HHS from denying Medicare home health benefits to individuals who supplement the care provided by Medicare. If families want to pay privately for additional care needed by relatives, they should be able to do so without causing a loss of Medicare's benefits.

10. Congress should clarify HHS rules with respect to discrete costing. At the present time, free-standing HHAs are barred from using more sophisticated accounting methods. The guidelines need to be revised in order to allow HHAs to recover costs which are legitimately contributable to the Medicare program.

11. Congress should require HHS to regulate HMOs in the same way that they regulate hosptials, nursing homes, hospices and other providers who seek to provide home health care. Each of the above entities must seek and obtain a separate certification from HHS if it plans to offer home care. The rule should be made applicable to HMOs.

12. Congress should require HHS to withdraw Forms 485-488 until these forms can be perfected through appropriate field trials.

13. Congress should block the retroactive application of HHS rules requiring all HHAs to post a bond or establish an escrow. HHS has offered no evidence that such new rules are desirable or need to be applied to existing HHAs.

14. Congress should remove unfair limitations which recently have been placed on the receipt of PIP payments (periodic interim payments).

15. Congress should enact proposals such as S. 1249 which passed the Senate in 1985, and S. 1793, expanding the scope of pediatric home care.

16. Congress should instruct HHS to allow coverage for so called hi-tech home care services, such as IV chemotherapy, when ordered by a physician as part of appropriate home care therapy.

17. Congress should move toward the enactment of a prospective payment system for home health agencies.

18. Congress should encourage family members to care for their relatives at home through appropriate tax deductions.

19. Congress should encourage all states to enact legislation similar to the Nursing Home Without Walls program which has been so successful in New York state.

20. Congress should enact comprehensive long-term care legislation as part of any catastrophic health insurance plan which it considers.

XI. APPENDIX

APPENDIX I

QUESTIONNAIRE TO ALL HOME HEALTH AGENCIES IN THE U.S.

Please return to: National Association for Home Care
519 C Street, N.E.
Washington, D.C. 20002

1. Have you seen an increase in the number of Medicare denials over the past year? ___Yes ___No

   If yes, by approximately what percent?

   ___ 0-10% ___ 26-50%
   ___ 11-25% ___ Over 50%

2. Have you seen an increase in denials with the explanation the client is not thought homebound? ___ Yes ___ No

3. Have you seen an increase in cases denied because the client does not meet the "intermittent care" criteria? ___ Yes ___ No

4. Have you seen an increase in the number of denials because the client allegedly does not meet the "skilled nursing" requirement? ___Yes ___No

5. Have you experienced an increase in the number of so called "technical denials"? ___ Yes ___ No

6. Have you had an increase in denials for other reasons? Please specify:

   _____

   _____

   _____

7. Has your agency lost its waiver of liability status more often in the last four quarters than in the previous four quarters? ___ Yes ___ No

8. Has your agency experienced a slow down or delay in Medicare payments over the past year? ___ Yes ___ No

9. Has your agency seen an increase in the level of audit exceptions and disallowances in 1985 as opposed to previous years? ___ Yes ___ No

10. Has your agency seen a significant increase in the amount of paperwork burden responding to the need for documentation and/or other HCFA requirements in the past year? ___ Yes ___ No

11. Has your agency seen an increase in the number of sicker patients requiring intensive medical and nursing care as a result of DRG reimbursement to hospitals? ___ Yes ___ No

12. Government statistics show that 5.5 million Americans are in need of home care services and that the need is increasing. Do you feel that a significant number of Americans are going without the home care services they need in your community? ___ Yes ___ No

13. Effective July 1, 1985, HCFA placed into effect new cost limits and a new method of computing cost limits. If these limits are allowed to stay in place, will they significantly reduce Medicare repayment to your agency? ___ Yes ___ No

    If YES, can you give percentage of reduction you expect and/or the estimates of total dollars which will be lost during the first year?

    _____

    _____

14. Is your agency reducing its dependence on Medicare? ___ Yes ___ No

15. Is your agency considering withdrawing from Medicare? ___ Yes ___ No

16. Can you share with us any case histories of patients denied Medicare home health benefits for what you felt were clearly inappropriate reasons? (No names please. Refer to individuals as Client A, Client B, etc.)

    Additional comments on the back of this questionnaire or otherwise are welcome.